STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395471	A. BLDG: 00 B. WING:	12/12/2025

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
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance Survey completed on December 12, 2025, it was determined that Armstrong Rehabilitation and Nursing Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0550 SS=D		F 0550		

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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F 0550 SS=D	Continued from page 1 483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 0550	Resident R 3 had a catheter dignity bag placed on their catheter bag and resident R44 was fed their meal that day of survey. All residents with catheters will be reviewed to assure dignity bags are placed on catheter bags and residents with an order for assisted feeding will be reviewed and fed their meals. Director of Nursing will educate nursing staff on placement of dignity bags on the catheter bags and all residents that are assisted with meals will be fed when their tray is delivered. Director of Nursing or designee will audit catheter bags for dignity bag placement 3 times a week for 3 weeks, then 3 times a week for 2 weeks and 3 times a week for 1 week. Residents with orders for assistance to be fed will be reviewed and audited during mealtime that assistance was provided weekly times 3 and monthly times 2. Results will be turned into monthly Quality Assurance meeting	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

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F 0550 SS=D	Continued from page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:	F 0550		

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F 0550 SS=D	Continued from page 3 Based on review of facility admission packet, facility policy, clinical records, observation, and staff interviews it was determined that the facility failed to ensure that care was provided in a manner which maintained resident dignity for two residents (Resident R3 and R44). Findings include: Review of the facility "Admission Packet" policy dated 5/28/21, indicated the facility shall protect and promote the rights of each resident that include the right to a dignified existence, self-determination, communication with and access to, persons and services inside and outside the facility. Review of the facility "Catheter Care" policy dated 10/13/25 indicated that the facility will ensure that residents indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Privacy bags will be available and catheter drainage bags will be covered at all times while in use.	F 0550		

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F 0550 SS=D	Continued from page 4 Review of the clinical record indicated Resident R3 was admitted to the facility on 11/18/25. Review of Resident R3's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/24/25, indicated diagnoses of depression, neurogenic bladder (nerve damage that interrupts bladder control), quadriplegia (a paralysis that affects all body limbs). Section H Bowel and Bladder H0100A indicated an indwelling catheter. Review of Resident R3's care plan dated 11/19/25, indicated the resident has an indwelling urinary catheter related to neurogenic bladder. During an observation on 12/8/25, at 11:15 a.m. Resident R3's catheter draining bag was observed hanging on his bed frame without a privacy cover applied. During an interview on 12/8/25, at 11:20 a.m. Licensed Practical Nurse (LPN) Employee E9 confirmed Resident R3's catheter draining bag did	F 0550		

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F 0550 SS=D	Continued from page 5 not have a privacy cover and that the facility failed to ensure that care was provided in a way that maintained Resident R3's dignity. Review of Resident R44's clinical record indicated the resident was admitted to the facility on 1/23/24. Review of Resident R44's MDS dated 11/2/25, indicated diagnoses of high blood pressure, cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Section GG Functional Abilities GG0130 Eating was coded as a "1", indicating resident is dependent and the helper does all of the effort. Resident does none of the effort to complete the activity. Review of Resident R44's physician orders dated 7/11/25, indicated resident is total assist with self-feeding to promote nutritional intake. Review of Resident R44's care plan on 12/8/25, at 11:50 a.m. indicated resident is total assist with	F 0550		

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F 0550 SS=D	Continued from page 6 self-feeding to promote nutritional intake. During an observation on 12/8/25, at 11:55 a.m. two staff members were passing lunch trays on the unit. Nurse Aide Employee E12 placed Resident R44's lunch tray on the bedside table in front of her and then left the room to continue passing lunch trays. During an interview on 12/8/25, at 12:01 p.m. LPN Employee E9 confirmed the above findings, and that resident should have been assisted with lunch when the lunch tray was delivered. During an interview on 12/8/25, at 2:45 p.m. Director of Nursing confirmed that the facility failed to ensure that care was provided in a manner which maintained resident dignity for two residents (Resident R3 and R44). Pa. Code: 211.10 (c)(d) Resident care policies. Pa. Code: 211.12(d)(1)(5) Nursing services.	F 0550		

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F 0550 SS=D	Continued from page 7	F 0550		
F 0575 SS=C	483.10(g)(5)(i)(ii) Required Postings §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by:	F 0575	No residents were directly affected by the posting, but they were corrected the week of survey All postings were corrected so residents and families have the correct information available for their use if needed. Administrator or designee will educate Administration staff on proper signage for state survey agencies, adult protective services and the Medicaid fraud unit. Administrator or designee will audit the three postings weekly times 3 and monthly times 2. Results will be turned into monthly Quality Assurance meeting	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

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F 0575 SS=C	Continued from page 8	F 0575		

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F 0575 SS=C	Continued from page 9 Based on observations and staff interview, it was determined that the facility failed to post complete contact information for State Survey Agency, Adult Protective Services, and Medicaid Fraud Unit as required, and failed to post a statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation on three of three floors (First Floor, Second Floor, and Third Floor). Findings include: During observations completed on 12/9/25, of the First Floor, Second Floor, and Third Floor, postings of the contact information for State Survey Agency, Adult Protective Services, and Medicaid Fraud Unit failed to include email addresses for the above agencies as required, and also failed to include a statement that the resident may file a complaint with the State Survey Agency During interview, on 12/9/25, at 2:20 p.m., the Nursing Home Administrator confirmed that the	F 0575		

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F 0575 SS=C	Continued from page 10 facility failed to post complete contact information for State Survey Agency, Adult Protective Services, and Medicaid Fraud Unit, and failed to post a statement that the resident may file a complaint with the State Survey Agency as required, on three of three floors. 28 Pa. Code: 201.14(a)Responsibility of licensee. 28 Pa. Code: 201.18(e) Management.	F 0575		
F 0578 SS=D		F 0578		

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F 0578 SS=D	Continued from page 11 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	Resident R 3 and resident R44 were both given the opportunity for Advanced Directives and the Social Worker documented they were provided. Social Worker will look back for the past 30 days and review documentation of advanced directives with new Admissions Administrator educated Social Worker on need to document advanced directives were given to new admissions. Social Worker or designee will new admission advanced directives documentation weekly times 3 and monthly times 2. Results will be turned into monthly Quality Assurance meeting	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

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F 0578 SS=D	Continued from page 12 directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 0578		

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F 0578 SS=D	Continued from page 13 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide documentation that residents or resident representatives were given the opportunity to formulate an advance directive (a written instruction such as a living will or durable power of attorney for health care for when the individual is incapacitated) for two of four residents reviewed (Resident R3, and R64). Findings include: A review of the facility " Residents' Rights Regarding Treatment and Advance Directives" policy dated 10/13/25, indicated that the facility will support and facilitate a resident's right to request, refuse or discontinue medical or surgical treatment and to formulate advance directives. On admission, the facility will determine if the resident has executed an advance directive and if not, determine whether the resident would like to formulate an advance directive. The facility will provide the resident or resident representative information on formulating	F 0578		

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F 0578 SS=D	Continued from page 14 advance directives. Review of the clinical record indicated Resident R3 was admitted to the facility on 11/18/25. Review of Resident R3's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/24/25, indicated diagnoses of depression, neurogenic bladder (nerve damage that interrupts bladder control), quadriplegia (a paralysis that affects all body limbs). A review of the clinical record failed to reveal an advanced directive or documentation that Resident R3 was given the opportunity to formulate an Advanced Directive. Review of Resident R64's clinical record indicated the resident was admitted to the facility on 10/25/25. Review of Resident R64's MDS dated 10/29/25, indicated diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing	F 0578		

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F 0578 SS=D	Continued from page 15 breathlessness), muscle weakness, and cancer (uncontrolled growth and division of abnormal cells). A review of the clinical record failed to reveal an advanced directive or documentation that Resident R64 was given the opportunity to formulate an Advanced Directive. During an interview on 12/10/25, at 1:50 p.m. Social Worker Employee E15 confirmed that the facility failed to provide documentation that residents or resident representatives were given the opportunity to formulate an advance directive for two of four residents reviewed (Resident R3, and R64). 28 Pa. Code: 201.29(b) Resident rights.	F 0578		

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F 0656 SS=D	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 0656	Resident R7 was at hospital and care plan was corrected upon her return December 22, 2025 All residents with suicide ideations care plans were reviewed to make sure they were person centered care plans Director of Nursing or Designee will educate Nursing Administration staff on person centered care plans for residents with suicide ideation. Director of Nursing or designee will audit care plans with suicide ideations weekly times 3 and monthly times 2. Results will be turned into monthly Quality Assurance meeting	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0656 SS=D	Continued from page 17 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656		

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F 0656 SS=D	Continued from page 18 Based on review of clinical records and staff interviews it was determined that the facility failed to develop a person-centered care plan with interventions for one of three residents reviewed (Resident R7). Findings include: Review of the clinical record indicated Resident R7 was admitted to the facility on 8/3/24. Review of the Minimum Data Set (MDS - a periodic assessment of resident care needs) dated 11/7/25, included diagnoses of suicidal ideation (when you think about, consider or feel preoccupied with the idea of death and suicide), schizophrenia (serious mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior) and anxiety disorder (group of mental health conditions that cause fear, dread and other symptoms).	F 0656		

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F 0656 SS=D	Continued from page 19 Review of the plan of care for mood and behavior indicated the, a focus goal and intervention section: the focus was "suicidal ideations" with a goal section that failed to include a goal for suicidal ideations, and interventions that said, " I use plastic silverware". No other interventions were documented in the plan of care or in the clinical record. Review of the clinical record progress notes indicated: 12/5/25: alerted by Nurse Aide that Resident R7 wished she was not here anymore. Stated that she had no purpose here anymore. This writer notified RN on duty. After dinner was alerted that resident tried to stab herself with a plastic fork and expressed that she did now want to be alive anymore. " 12/6/25: Staff just informed this nurse that Resident R7 tried to cut herself with a plastic spoon." During an interview on 12/11/25, at 3:05 p.m. the	F 0656		

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F 0656 SS=D	Continued from page 20 Director of Nursing and Nursing Home Administrator were informed that the facility failed to develop a person-centered care plan for Resident R7 that included interventions to assist with suicidal ideations. Pa. Code 201.24 (c) (4) Admission policy 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.	F 0656		
F 0686 SS=D		F 0686		

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F 0686 SS=D	Continued from page 21 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	Resident 8 was given skin assessment during survey week All residents with newly reported skin issues were reviewed to make sure they have the weekly skin notes. Director of Nursing or Designee will educate Nursing Administration staff on proper skin issue documentation Director of Nursing or designee will Audit reports of new skin issues for skin assessments weekly times 3 and monthly times 2. Results will be turned into monthly Quality Assurance meeting	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/05/2026**

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F 0686 SS=D	Continued from page 22 Based on review of facility policies, clinical records, facility documents and staff interviews, it was determined that the facility failed to ensure residents were assessed, and provided necessary treatment and services, consistent with professional standards of practice, for a pressure ulcer (PU/PIs- injuries to skin and underlying tissue resulting from prolonged pressure on the skin) for one of four residents (Resident R8). Findings include: Review of facility policy "Pressure Injury Prevention and Management" dated 10/13/25, indicated the facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injury. The facility shall establish and utilize a systemic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove	F 0686		

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F 0686 SS=D	Continued from page 23 underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. Licensed nurses will conduct a pressure injury risk assessment on all residents upon admission/re-admission, weekly x four weeks, then quarterly or whenever the resident's condition changes significantly. Licensed nurses will conduct a full body skin assessment on all residents upon admission/readmission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. The goals and preferences of a resident and/or authorized representative will be included in the plan of care. Interventions will be documented in the care plan and communicated to all relevant staff. Interventions on a resident's plan of care will be modified as needed. Review of the clinical record indicated Resident R8 was admitted to the facility on 2/19/25. Review of Resident R8's clinical record progress notes dated 9/17/25, at 9:57 a.m., revealed new	F 0686		

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F 0686 SS=D	Continued from page 24 skin issue reported - Resident (R8) seen by wound team for consult. Resident (R8) found to have a S3PI (stage 3 pressure injury = full-thickness skin loss, potentially extending into the subcutaneous tissue, and may present with undermining and tunneling) to coccyx (commonly referred to as the tailbone), noted that resident (R8) has had a decline in overall condition. Review of Resident R8's clinical record wound consultant note dated 9/17/25, indicated that on the coccyx, a linear shaped open wound with moist pink tissue at base, minimal drainage. Edges unattached, peri wound intact. No odor, no warmth, no erythema. Measurement 1.5 x 0.5 x 0.2 cm (centimeters). Coccyx S3PI. Review of Resident R8's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/2/25, indicated diagnoses Chronic obstructive pulmonary disease (progressive lung disease characterized by airway inflammation and damage, leading to symptoms such as shortness of breath,	F 0686		

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F 0686 SS=D	Continued from page 25 chronic cough, and mucus production), diabetes mellitus (chronic condition characterized by high levels of glucose in the blood due to the body's inability to produce or effectively use insulin), and bipolar disorder (mental health condition that causes extreme mood swings). Section M - Skin Condition, M0300C indicated a "1" = Number of Stage 3 pressure ulcers. Review of physician order dated 9/17/25, indicated SSD (silver sulfadiazine) External Cream 1%, apply to coccyx topically two times a day for wound care. Review of Resident R8's clinical record reviewed on 12/9/25, failed to reveal weekly wound documentation since wound was identified on 9/17/25. During an interview on 12/9/25, at 1:03 p.m., Wound Care Licensed Practical Nurse (WCLPN) Employee E22 revealed that Resident R8's S3PI on coccyx is healed, and that there is no weekly wound documentation in clinical record regarding coccyx	F 0686		

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F 0686 SS=D	Continued from page 26 skin breakdown from 9/17/25, to current date. Review of the clinical record failed to indicate that a Braden Scale for Predicting Pressure Sore Risk has been updated since 3/19/25, when Resident R8 was identified at "moderate risk" for skin breakdown. Review of plan of care for pressure ulcer development, initiated 2/20/25, updated 9/25/25, indicated that Resident R8 has a stage 3 to coccyx 9/16/25. During an interview on 12/11/25, at 9:00 a.m., the Director of Nursing (DON) confirmed that a Braden Scale for Predicting Pressure Sore Risk had not be completed for Resident R8 since 3/19/25; confirmed that the facility failed to document weekly on Resident R8's coccyx pressure injury; and failed to update Resident R8's care plan timely related to current skin status. During an interview on 12/12/25, at 2:45 p.m., the Nursing Home Administrator (NHA) and Director	F 0686		

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F 0686 SS=D	Continued from page 27 of Nursing (DON) confirmed that the facility failed to ensure residents were assessed, and provided necessary treatment and services, consistent with professional standards of practice, for a pressure ulcer (PU/PIs- injuries to skin and underlying tissue resulting from prolonged pressure on the skin) for one of four residents (Resident R8). 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.	F 0686		
F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 28 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	Resident R7 was sent to hospital on December 6, 2025, and escorted by a staff member during transport. No other residents presented with suicide ideations currently that needed one to one care. Director of Nursing or Designee will educate Nursing staff on protocol when a resident with suicide ideation starts to act on them Director of Nursing or designee will audit resident prevention with suicide ideations weekly times 3 and monthly times 2. Results will be turned into monthly Quality Assurance meeting	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

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F 0689 SS=D	Continued from page 29 Based on review of facility policy, clinical record review and staff interview it was determined that the facility failed to provide adequate supervision for one of three residents with mental health concerns to prevent attempts of suicide (Resident R7). Findings include: Review of facility policy "Accidents and Supervision" dated 10/13/25, indicated: " The resident environment will remain free as free of accident hazards as possible. Each resident will receive adequate supervision and assistive devices to prevent accidents". Revie of facility policy "Suicide ideation or attempt), dated 10/13/25, indicated: "Plan of care for a resident after suicide ideation or attempt is to focus on immediate safety, comprehensive mental health evaluation, collaborative safety planning, and ongoing emotional support and monitoring. Immediate intervention: Ensure safety Do not leave the resident alone. One - on - One observation by a	F 0689		

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F 0689 SS=D	Continued from page 30 staff member until a professional evaluation is completed or risk is lowered. Remove any lethal means. Immediately search the resident's surroundings and remove any items that could be used for self-harm (e.g. sharp objects, call bell cord, belts). Medical attention. Ensure that the resident receives immediate medical care for any physical injuries resulting from the attempt. Emergency contacts. Notify the MD immediately. Notify the crisis team and emergency contact person. Involve mental health professionals. Arrange for an urgent screening and comprehensive evaluation by mental health professional." Review of the clinical record indicated Resident R7 was admitted to the facility on 8/3/24. Review of Resident R7 Minimum Data Set (MDS - a periodic assessment of resident care needs) dated 11/7/25, included diagnoses of suicidal ideation (when you think about, consider or feel preoccupied with the idea of death and suicide), schizophrenia (serious mental health condition that affects how	F 0689		

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F 0689 SS=D	Continued from page 31 people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior) and anxiety disorder (group of mental health conditions that cause fear, dread and other symptoms). Review of clinical record progress notes indicated the following: 12/5/25: alerted by Nurse Aide that Resident R7 wished she was not here anymore. Stated that she had no purpose here anymore. This writer notified RN on duty. After dinner was alerted that resident tried to stab herself with a plastic fork and expressed that she did now want to be alive anymore. " 12/6/25: Staff just informed this nurse that Resident R7 tried to cut herself with a plastic spoon." During an interview on 12/10/25, at 2:20 p.m. Director of Nursing (DON) andNursing Home Administrator (NHA) confirmed that on 12/5/25 and 12/6/25 Resident R7 experienced suicidal	F 0689		

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F 0689 SS=D	Continued from page 32 ideations. During an interview on 12/12/25, at 1:40 p.m. NHA were informed that the facility failed to provide adequate supervision to prevent attempts of suicide for Resident R7. 28 Pa. Code 211.10 (d) Resident care policies.	F 0689		
F 0692 SS=D		F 0692		

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	395471	A. BLDG: 00 B. WING:	12/12/2025

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
F 0692 SS=D	Continued from page 33 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	Resident 8 received an updated nutritional assessment and updated care plan All residents in the last 30 days that have a nutritional concern will be reviewed for having a nutritional assessment and updated care plan based on their needs Administrator or designee will educate the Registered Dietician and Certified Dietary Manager on the need to do accurate nutrition assessment and updating the care plans based on their nutritional needs. Registered Dietician or designee will audit 3 resident nutrition assessments and care plans weekly times 3 and monthly times 2. Results will be turned into monthly Quality Assurance meeting	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/06/2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0692 SS=D	Continued from page 34 Based on a review of the facility policy, clinical record review and staff interview, it was determined that the facility failed to accurately assess the nutritional status, and failed to update an individualized care plan to address the resident's specific nutritional concerns for one of three residents (Resident R8) records reviewed. Findings include: Review of facility's policy "Nutritional Management", dated 10/13/25, indicated the facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. A comprehensive nutritional assessment will be completed by a dietitian within 72 hours of admission, annually, and upon significant change in condition. The resident's goals and preferences regarding nutrition will be reflected in the resident's plan of care. Review of the clinical record indicated Resident R8	F 0692		

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F 0692 SS=D	Continued from page 35 was admitted to the facility on 2/19/25. Review of Resident R8's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/2/25, indicated diagnoses Chronic obstructive pulmonary disease (progressive lung disease characterized by airway inflammation and damage, leading to symptoms such as shortness of breath, chronic cough, and mucus production), diabetes mellitus (chronic condition characterized by high levels of glucose in the blood due to the body's inability to produce or effectively use insulin), and bipolar disorder (mental health condition that causes extreme mood swings). Section M - Skin Condition, M0300C indicated a "1" = Number of Stage 3 pressure ulcers. During an interview on 12/11/25, at 9:32 a.m., Registered Dietitian (RD) Employee E21 revealed that a comprehensive nutritional assessment (form "Nutrition Assessment V.3") is completed on admission/readmission, annually, and with a significant change in condition.	F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0692 SS=D	Continued from page 36 Review of Resident R8's clinical record failed to reveal that a comprehensive nutritional assessment (form "Nutrition Assessment V.3") was completed that addressed Resident R8's current nutritional status related to Stage 3 pressure ulcer by updating nutrient needs, evaluating laboratory/diagnostic values, and evaluating overall need for additional nutritional interventions for pressure ulcer repair based on information submitted on Significant Change MDS assessment dated 10/2/25. Review of current nutritional plan of care initiated 2/22/5, updated 10/20/25, failed to indicate a nutritional focus/concern, goals, and interventions to address Resident R8's stage 3 pressure ulcer as identified in MDS dated 10/2/25. During an interview on 12/11/25, at 10:00 a.m., RD Employee E21 confirmed that a comprehensive nutritional assessment was not completed as required for a Significant Change MDS assessment dated 10/2/25, which addressed Resident R8's	F 0692		

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F 0692 SS=D	Continued from page 37 change in nutritional needs due to a Stage 3 pressure ulcer, and failed to update Resident R8's care plan to reflect current skin breakdown. During an interview on 12/12/25, at 2:45 p.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility failed to accurately assess the nutritional status and failed to update an individualized care plan to address the resident's specific nutritional concerns for one of three residents (Resident R8) records reviewed. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 211.12(d)(5) Nursing services.	F 0692		
F 0695 SS=D		F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0695 SS=D	Continued from page 38 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	Resident 3 and Resident 65 had their nasal cannula bagged and dated immediately when found. All residents that have a nasal cannula will be reviewed to assure they are bagged when not in use and all tubing is dated. Director of Nursing or Designee will educate Nursing staff on protocol for bagging the oxygen equipment and dating the tubing. Director of Nursing or designee will audit bagging the oxygen equipment and dating the tubing. weekly times 3 and monthly times 2. Results will be turned into monthly Quality Assurance meeting	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/05/2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0695 SS=D	Continued from page 39 Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for two of four residents (Resident R3 and R65). Findings include: Review of facility policy "Oxygen Administration" dated 10/13/25, indicated oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Change oxygen tubing weekly and as needed. Keep delivery devices covered in plastic bag when not in use. Review of the clinical record indicated Resident R3 was admitted to the facility on 11/18/25. Review of Resident R3's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/24/25, indicated diagnoses of depression, neurogenic bladder (nerve damage that interrupts	F 0695		

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F 0695 SS=D	Continued from page 40 bladder control), quadriplegia (a paralysis that affects all body limbs). Review of a physician's orders dated 12/1/25, indicated to administer oxygen two liters per minute for shortness of breath as needed. During an observation on 12/8/25, at 10:55 a.m. Resident R3 was lying in bed. The oxygen concentrator was located beside the bed with the nasal cannula (a thin tubing that delivers oxygen from the oxygen concentrator to the nose) laid over top, not stored in a bag. During an interview on 12/8/25, at 11:20 a.m. Licensed Practical Nurse (LPN) Employee E9 confirmed that the nasal cannula was not stored in a bag when not in use, as required. Review of the clinical record indicated Resident R65 was admitted to the facility on 5/31/25. Review of Resident R65's MDS dated 9/7/25, indicated diagnoses of depression, heart failure (a progressive heart disease that affects pumping action	F 0695		

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F 0695 SS=D	Continued from page 41 of the heart muscles), and chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness). Review of physician's orders dated 6/6/25, indicated to administer Ipratrpium-Albuterol (a medication used to treat respiratory diseases) via nebulizer (a machine that delivers medication through inhalation) every four hours if needed. During an observation on 12/8/25, at 11:05 a.m. Resident R65 was lying in bed. The nebulizer machine and tubing were lying on bedside table. The tubing was not dated and was not stored in a bag. During an interview on 12/8/25, at 11:25 a.m. LPN Employee E9 confirmed that the nebulizer tubing failed to have a date on it and was not stored in a bag when not in use, as required. During an interview on 12/8/25, at 2:45 p.m. the Director of Nursing confirmed that the facility failed	F 0695		

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F 0695 SS=D	Continued from page 42 to provide appropriate respiratory care for two of four residents (Resident R3 and R65). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services	F 0695		
F 0730 SS=E		F 0730		

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F 0730 SS=E	Continued from page 43 483.35(e)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(e)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 0730	For Nurse Aide (NA) Employee's 4, 5, 6, 7, and 8 the annual evaluations were completed Nurse Aides employment files will be reviewed to make sure annual evaluations have been completed. Evaluations will be completed annually based on hired date. Human Resource Director will educate Director of Nursing on protocol for annual evaluations. Human resource Director or designee will audit employee evaluations and set a schedule for the upcoming year. Results will be turned into monthly Quality Assurance meeting	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

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F 0730 SS=E	Continued from page 44 Based on review of facility policy, personnel records and staff interviews it was determined that the facility failed to complete annual performance evaluations for five of five nurse aides (NA) (NA Employees E4, E5, E6, E7, and E8). Findings include: Review of NA Employee E4's personnel record indicated a hire date of 9/19/11. Review of NA Employee E5's personnel record indicated a hire date of 9/21/18. Review of NA Employee E6's personnel record indicated a hire date of 2/26/23. Review of NA Employee E7's personnel record indicated a hire date of 8/27/23. Review of NA Employee E8's personnel record indicated a hire date of 10/2/23.	F 0730		

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F 0730 SS=E	Continued from page 45 Review of personnel records did not include an annual performance evaluation based on the date of hire for NA Employees E4, E5, E6, E7, and E8. During an interview on 12/9/25, at 1:57 p.m. Human Resources Employee E10 confirmed that the facility failed to complete annual performance evaluations for five of five nurse aides as required. 28 Pa Code: 201.14 (b) Responsibility of licensee 28 Pa Code: 201.18 (b)(1)(3) Management	F 0730		
F 0745 SS=D		F 0745		

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F 0745 SS=D	Continued from page 46 483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 0745	Resident R7 was sent to hospital on December 6, 2025, and Social Services needs would addressed when she returned. No other residents currently present with suicide ideations that need further social service interventions. Director of Nursing or Designee will educate Social Services on protocol when a resident with suicide ideation discusses dreams to provide the necessary therapy or interventions. Social Services or designee will audit resident prevention with suicide ideations weekly times 3 and monthly times 2. Results will be turned into monthly Quality Assurance meeting	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

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F 0745 SS=D	Continued from page 47 Based on review of facility policy, clinical documentation and staff interview it was determined that the facility failed to provide sufficient and timely social services to one of three residents reviewed (Resident R7). Findings include: Review of facility policy dated 10/13/25, "Behavioral Health Services " indicated: It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning." Review of facility policy dated 10/13/25, "Suicide ideation or attempt" indicated: Plan of care for a resident after suicide ideation or attempt is to focus on immediate safety, comprehensive mental health evaluation, collaborative safety planning and ongoing emotional support and monitoring." Review of the clinical record indicated Resident R7	F 0745		

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F 0745 SS=D	Continued from page 48 was admitted to the facility on 8/3/24. Review of the Minimum Data Set (MDS - a periodic assessment of resident care needs) dated 11/7/25, included diagnoses of suicidal ideation (when you think about, consider or feel preoccupied with the idea of death and suicide), schizophrenia (serious mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior) and anxiety disorder (group of mental health conditions that cause fear, dread and other symptoms). Review of Resident R7 clinical record indicated: Therapeutic evaluation in 10/16/25, where clinician ended therapy services. Review of clinical record from October 2025 to December 2025 failed to show additional therapy services.	F 0745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0745 SS=D	Continued from page 49 12/5/25: alerted by Nurse Aide that Resident R7 wished she was not here anymore. Stated that she had no purpose here anymore. This writer notified RN on duty. After dinner was alerted that resident tried to stab herself with a plastic fork and expressed that she did now want to be alive anymore. " 12/6/25: Staff just informed this nurse that Resident R7 tried to cut herself with a plastic spoon." During an interview on 12/11/25, at 12:43 p.m. Social Worker Employee E15 indicated: Resident R7 had a known history of suicidal ideations and attempts- that Resident R7 had expressed to Social Worker Employee E7 that she was experiencing a recurring dream that scared her and the Social Worker Employee E7 described as potential trauma. Social Worker Employee E7 was aware that therapy had ended in October and besides medication management (which did not take place between October thru December 2025) Resident R7 was not receiving clinical therapeutic services.	F 0745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395471	A. BLDG: __00_____ B. WING: _____	12/12/2025

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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F 0745 SS=D	Continued from page 50 During an interview on 12/11/25, at 2:31 p.m. Contractor Clinical Therapist Employee E24 indicated that she had discharged Resident R7 due to cognitive decline. When asked what the cognitive decline change was - Contractor Clinical therapist Employee E24 indicated that she wasn't communicating with the clinical and that's why she discharged her. Contractor Clinical Therapist Employee E24 asked if anything had happened to Resident R7. No documentation was noted of the facility contacting the clinical therapist or CRNP for psychotropic medication monitoring. During an interview on 12/11/25, at 3:50 p.m. nursing staff indicated the following: Resident R7 did experience a dream which scared her - and she was consistent with talking about the dream. During an interview on 12/12/25, at 1:42 p.m.	F 0745		

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F 0745 SS=D	Continued from page 51 Nursing Home Administrator was informed that the facility failed provide sufficient and timely social services to one of three residents reviewed (Resident R7). 28 Pa. Code 201.14(b) Responsibility of licensee. 28 Pa. Code 211.16(a)(1)Social services. 28 Pa. Code 201.29(a) Resident rights.	F 0745		
F 0760 SS=D		F 0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0760 SS=D	Continued from page 52 483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 0760	Resident R36 was assessed by the RN. Resident R36 has had no ill effected due to the medication error. Employee E18 was re-educated on the Facility Medication Policy by the Director of Nursing. The Director of Nursing or designee will re-educate Licensed nurses on the Facility Medication Policy. The Director of Nursing or designee will audit 3 medication passes for 3 weeks. Then 2 medication passes weekly for 4 weeks. Results will be reviewed monthly by the Quality Assurance Committee.	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/06/2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0760 SS=D	Continued from page 53 Based on review of facility policy, clinical record review, observation, and interviews with staff, it was determined that the facility failed to ensure that residents are free of significant medication errors for one of five residents reviewed (Resident R36). Findings include: Review of facility "Medication Administration " policy dated 10/13/25, indicated medications are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice. Ensure that the six rights of medication administration are followed: - Right resident - Right drug - Right dose - Right route - Right time - Right documentation Review of the clinical record indicated Resident R36 was admitted to the facility on 3/10/23.	F 0760		

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F 0760 SS=D	Continued from page 54 Review of Resident R36's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/2/25, indicated diagnoses of arthritis, depression, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of a physician order dated 12/1/25, indicated to inject eight units of Insulin Aspart (a medication used to treat high blood sugar) subcutaneously (under the skin) with meals. During an interview on 12/11/25, Nurse Aide Employee E11 stated that breakfast trays are usually on the unit at 7:55 a.m. During a med pass observation on 12/11/25, at 9:42 a.m. Licensed Practical Nurse (LPN) Employee E18 gave Resident R36 eight units of Insulin Aspart. During an interview on 12/11/25, at 9:45 a.m. LPN Employee E18 stated, "I'm late with her medicine. It is ordered with meals. I should have given it with her	F 0760		

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F 0760 SS=D	Continued from page 55 breakfast." During an interview on 12/11/25, at 2:45 p.m. Director of Nursing confirmed that the facility failed to ensure that Resident R36 received her medication as ordered and that residents were free of significant medication errors for one of five residents reviewed (Resident R36) as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10 (c)(d) Resident Care policies. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.	F 0760		
F 0761 SS=E		F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0761 SS=E	Continued from page 56 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	During the survey all medication and supplies that were expired were removed from med carts and supply rooms. All insulins in all medication carts and supplies in supply rooms will be checked for expirations dates and removed if expired. Director of Nursing or Designee will educate Licensed nurses on protocol for insulin dating and supply expiration dates. Director of Nursing or designee will audit Insulin dates and supply expiration dates weekly times 3 and monthly times 2. Results will be turned into monthly Quality Assurance meeting	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0761 SS=E	Continued from page 57 Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly store medications and/or biologicals in three of five medication rooms (Second Floor (2C) Medication Room, Third Floor (3A) Medication Room, and Third Floor (3C) Medication Room) and failed to properly store medication in two of three medication carts (3BC Medication Cart and 2BC Medication Cart). Findings include: Review of facility policy "Medication Storage" dated 10/13/25, indicated that medications will be stored in the medication rooms according to the manufacturer's recommendations. All medications rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed. Review of facility "Insulin Storage" policy dated 10/13/25, indicated that insulin must be stored	F 0761		

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F 0761 SS=E	Continued from page 58 securely in a locked area. Follow specific instructions for opened insulin vials/pens. Often good at room temperature for 28 days. Insulin vials/pens must be dated on the date they are initially used. During a medication cart review (3BC Medication Cart) on 12/9/25, at 12:40 p.m. the following were observed: (2) Lantus (a medication used to treat high blood sugars) vial with an opened date marked 11/3/25.Insulin Lispro (a medication used to treat high blood sugars) vial with an opened date marked 11/10/25.Lantus pen with an opened date marked 10/12/25.Lispo vial with an opened date marked 11/3/25.Insulin Aspart (a medication used to treat high blood sugars) vial with an opened date marked 11/3/25.Lantus vial with an opened date of 11/4/25.Novolog (a medication used to treat high blood sugars) was missing an opened and expired date. Lantus vial with an opened date marked 11/6/25.Lispro vial with an opened date marked 11/1/25.	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0761 SS=E	Continued from page 59 During an interview on 12/9/25, at 12:53 p.m. Licensed Practical Nurse (LPN) E13 confirmed the above findings and confirmed that they were expired. During a medication cart review (2BC Medication Cart) on 12/9/25, at 1:20 p.m. the following were observed: Lantus vial with an expiration date marked 12/8/25.Lantus vial with an opened date marked 10/24/25.During an interview on 12/9/25, at 1:35 p,m, Registered Nurse Employee E14 confirmed the above findings and confirmed that they were expired. During an observation on 12/10/25, at 10:16 a.m. of the Second Floor (2C) Medication Room the following was observed: -(2) Gallons of opened undated Natural Spring Water -(1) Spedi Catheter Internment French 16 Expired	F 0761		

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F 0761 SS=E	Continued from page 60 10/9/22 -(1) IV Tubing Administration Set Expired 11/10/23 -(3) IV Connecting Tubing 20' Length, 3/16' Diameter Expired 2/1/24 -(2) Gold Blood Tubes Expires 1/31/25 -(2) Blood Collection Set Expired 3/31/25 -(1) 300 milligram (mg) Bottle Fish Oil Expired 6/25 -(3) 50 mg Bottle Zinc Expired 7/25 -(1) Saccharomyces Boulardii Probiotic Expired 9/25 -(1) 1000 mg Bottle B12 Expired 10/15/25 -(2) 500 mg Bottle Vitamin C Expired 11/25 During an interview on 12/10/25, at 10:18 a.m. LPN Employee E19 confirmed the above items were expired. During an observation on 12/10/25, at 10:29 a.m. of the Third Floor (3A) Medication Room the following was observed: - (1) 50 mg Bottle Zinc Expired 7/25 -(1) 325mg Bottle of Iron Expired 8/25	F 0761		

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F 0761 SS=E	Continued from page 61 During an interview on 12/10/25, at 10:30 a.m. LPN, Employee E16 confirmed the above items were expired. During an observation on 12/10/25, at 10:36 a.m. of the Third Floor (3C) Medication Room the following was observed: -(1) Secondary Administration Set Expired 2/15/25 -(1) 400 mg Bottle Fish Oil Expired 7/25 -(3) IV Administration Set Expired 9/29/25 -(1) 500 mg Bottle Vitamin C Expired 11/25 During an interview on 12/10/25, at 10:40 a.m. LPN, Employee E13 confirmed the above items were expired. During an interview on 12/12/25, at approximately 3:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to properly store medications and/or biologicals in three of six medication rooms. 28 Pa. Code: 211.9(a)(1)(j.1)(k) Pharmacy	F 0761		

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F 0761 SS=E	Continued from page 62 services. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.	F 0761		
F 0836 SS=E	483.70(a)-(c) License/Comply w/ Fed/State/Locl Law/Prof Std §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the	F 0836	The invoices for transportation have been paid and resident 57 appointment made January 9, 2026 Invoices for transportation will be submitted timely and paid based on due date. Administrator or designee will review weekly invoices with Accounts Payable for payments status. Audit of transportation invoices for payment will be weekly times 3 and monthly times 2. Results will be turned into monthly Quality Assurance meeting	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0836 SS=E	Continued from page 63 basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by:	F 0836		

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F 0836 SS=E	Continued from page 64 Based on review of facility financial documents, interviews with residents, resident's families, and staff it was determined that the facility failed to pay bills in a timely manner. Findings include: Review of the Nursing Home Administrator job description indicated: " position purpose: leads, guides, and directs the operations of the healthcare facility in accordance with local, state, and federal regulations, standards and established facility policies and procedures to provide appropriate care and services to residents". Resident R57 was admitted to the facility on 7/26/23. Review of Resident R57 Minimum Data Set (MDS - a periodic assessment of resident needs) dated 11/14/25, indicated diagnosis of cerebral palsy (group of condition that affect movements and posture. I caused by damage that occurs to the	F 0836		

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F 0836 SS=E	Continued from page 65 developing brain, most often before birth) anxiety disorder (involve repeated episodes of sudden feelings of intense anxiety and or fear or terror), and abnormalities of gait (abnormal walking pattern). During an observation on the 2nd floor nursing unit on12/11/25, at 329 p.m. Resident R57 Indicated they wanted to talk with a surveyor. Resident R57 with Resident R57 Family Member on the video screen and Nurse Aide in to help with communicating with Resident R57 - stated that he wanted to know why he couldn't go to his eye appointment. Resident R57 Family member wife expanded to say - they had made an original appointment in October that needed to be canceled but re-made his eye appointment for Friday - the facility cancelled it. The appointment was for eye surgery due to resident not being able to see well out of his eye. Resident R57 Family Member indicated that the eye appointment was cancelled due to facility not having transportation. During an interview on 12/12/25, at 10:24 a.m.	F 0836		

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F 0836 SS=E	Continued from page 66 Scheduler Employee E23 indicated the following: Scheduler Employee E23 is responsible for setting up appointments for residents for transportation and for taking residents who are in wheelchairs and able to walk independently/with cane/wheeled walker to appointments. Per Scheduler Employee E23 the appointment was cancelled by the facility and the reason for cancelling was due to the transportation company not being paid by the facility. Scheduler Employee E23 indicated that this has happened before, but this was the longest period of time (no exact date provided). Review of facility documentation: Optimal transport contract: "This non-emergency wheelchair/stretcher transportation services agreement: Optimal transport is equipped and qualified to provide Non-Emergency Wheelchair/Stretcher transportation services to health care providers and assisted living facilities. Article 4- charges and billing - Optimal transport will invoice Armstrong	F 0836		

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F 0836 SS=E	Continued from page 67 Rehabilitation and Nursing monthly in accordance with the Fee schedule. Payment Armstrong Rehabilitation and nursing agree to pay Optimal Transport 100% of set rates." Review of facility documentation from October of 2025 to December 2025 indicated: 12 appointments being cancelled due to transportation not being available including Resident R57. During an interview on 12/12/25, at 2:00 p.m. Nursing Home Administrator confirmed that the facility failed to pay the transportation vendor in a timely manner. 28 Pa. Code 201.14 (a)(c) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management	F 0836		
F 0880 SS=E		F 0880		

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F 0880 SS=E	Continued from page 68 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Resident weren't directly affected with Personal Protective Equipment (PPE) usage. The residents were removed from their beds and rooms cleaned and the water management plan will be completed. All residents will be removed from their beds when rooms are cleaned, employees will be instructed what the protocol is for Infection control signs hanging on the doors. Director of Nursing or Designee will educate nursing staff on protocol for entering and leaving an infectious room and on educating a visitor on protocol when the resident units or rooms have the infectious signs posted The Director of Environmental services will educate their staff on cleaning an infectious room post isolation the proper protocol of removing the resident from bed. Director of Nursing or designee will audit Infectious rooms and proper PPE usage weekly times 3 and monthly times 2. The Director of Environmental will audit room cleans for removal of residents weekly times	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

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F 0880 SS=E	Continued from page 69 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	3 and monthly times 2. Results will be turned into monthly Quality Assurance meeting	

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F 0880 SS=E	Continued from page 70	F 0880		

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F 0880 SS=E	Continued from page 71 Based on review of facility policies, review of clinical record, observations, and staff interviews, it was determined that the facility failed to maintain proper infection control practices related to failing to use Personal Protective Equipment (PPE) appropriately in Droplet Isolation (a type of isolation that requires a gown, gloves, N95 (a respirator mask), and eye protection, which created the potential for the cross-contamination and the spread of diseases and infections for four out of four resident rooms (Rooms 301, 304, 305, and 312), failed to clean residents rooms appropriately after isolation was discontinued for three of three rooms (Rooms 304, 305, and 312), and failed to maintain a comprehensive program for water management to monitor the potential development and spread of Legionnaires (an infection of the lungs caused by bacteria, commonly spread by water) for 12 of 12 months. Findings Include: Review of facility "Infection Prevention and Control Risk Assessment Procedure" policy dated	F 0880		

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F 0880 SS=E	Continued from page 72 10/13/25, indicated the facility documents a risk assessment that utilizes an all-hazard approach. This risk assessment will be used for prioritizing activities of the facility's infection prevention and control program. Review of facility "Personal Protective Equipment" policy dated 10/13/25, indicated the facility promotes appropriate use of personal protective equipment to prevent the transmission of pathogens to residents, visitors, and other staff. Review of facility "Complete Room Cleaning" policy dated 10/13/25, indicated when cleaning a complete room, the room should be emptied and ready for cleaning. Starting in a clockwise rotation, clean, polish, scrub, scrape, dust, disinfect, sweep, wipe, and mop everything in the room. Review of facility "Water Management Program" policy dated 10/13/25, indicated the facility will establish water management plans for reduction the risk of legionellosis and other opportunistic	F 0880		

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F 0880 SS=E	Continued from page 73 pathogens in the facility's water systems based on nationally accepted standards. During an interview on 12/8/25, at 9:33 a.m. Infection Preventionist (IP) Employee E20 confirmed that Covid-19 (a respiratory infection) was present on the third floor. During a tour of the third floor, yellow signs were hung outside of several rooms that indicated Standard Precaution Airborne Contact Droplet Isolation. Prior to entering the room, clean hands, wear gown, N95, eye protection, and gloves. During multiple tours of the unit on 12/8/25, the following were observed with rooms that had isolation signs: - Nurse Aide (NA) Employee E11 was in a droplet isolation room with only a surgical mask on. - Licensed Practical Nurse (LPN) Employee E9 was in a droplet isolation room with a gown, gloves, and a surgical mask on. - NA Employee E12 exited a droplet isolation room	F 0880		

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F 0880 SS=E	Continued from page 74 and failed to discard N95 mask and was going into a non-isolation room with the N95 on. The State Agency (SA) requested the N95 be removed to prevent further spread of viruses. - NA Employee E111 was in a droplet isolation room with only a surgical mask on (Second time). - A family member stopped at nurses' station to talk to LPN Employee E9. The visitor had a mask on, however LPN Employee E9 failed to educate visitor prior to entering a droplet isolation room as to what should be worn to protect themselves. - NA Employee E11 was in a droplet isolation room with only a surgical mask (Third time). - NA Employee E12 was in a droplet isolation room with just a surgical mask and gloves on. During an interview on 12/8/25, at 12:10 p.m. LPN Employee E9 stated, "I should have told the visitor she needed a gown, eye wear and gloves on as well as her mask before she visited resident while we were talking." During an interview on 12/8/25, at 12:15 p.m. LPN	F 0880		

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F 0880 SS=E	Continued from page 75 Employee E9, NA Employee E11 and NA Employee E12 confirmed that the appropriate PPE were not used in droplet isolation rooms, and a visitor was not educated on the appropriate PPE to be worn prior to entering a droplet isolation room to prevent the spread of Covid-19 during a visit. During an interview on 12/9/25, at 11:33 a.m. IP Employee E20 stated that three Covid-19 isolation rooms (Rooms 304, 305, and 312) were discontinued due to residents testing negative for Covid-19 on this date. During a tour and observation on 12/9/25, at 1:10 p.m. residents in rooms 304, 305, and 312 were lying in bed. During an interview on 12/9/25, at 1:17 p.m. Housekeeper Employee E17 stated that the rooms were cleaned after the isolation was discontinued. When asked, "Were the residents in those rooms out of bed during the deep clean?", Housekeeper Employee E17 stated "No, they were still in bed."	F 0880		

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F 0880 SS=E	Continued from page 76 During an interview on 12/9/25, at 1:21 p.m. Housekeeper Employee E17 stated that when a room is deep cleaned after an isolation order was discontinued that residents should be out of bed so that beds, mattresses, and bedframes can be disinfected with cleaner and that bedding should be laundered. During an interview on 12/9/25, at 2:15 p.m. Nursing Home Administrator and Director of Nursing confirmed that the facility failed to maintain proper infection control practices related to failing to use PPE appropriately in Droplet Isolation which created the potential for the cross-contamination and the spread of diseases and infections for four out of four resident rooms (Rooms 301, 304, 305, and 312), and failed to clean residents rooms appropriately after isolation was discontinued for three of three rooms (Rooms 304, 305, and 312). During an interview on 12/11/25, at 10:07 a.m. the Nursing Home Administrator (NHA) stated he was	F 0880		

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F 0880 SS=E	Continued from page 77 unable to provide the facilities Legionella water management plan that included monitoring or auditing of facility for potential Legionella and failed to provide mapping of high opportunity areas where Legionella could be found in the facility water pipes. During an interview on 12/11/25, at 10:13 the NHA confirmed that the facility failed to maintain a comprehensive program for water management to monitor the potential development and spread of Legionnaires for 12 of 12 months. 28 Pa. Code: 211.10(d) Resident Care Policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing Services.	F 0880		
F 0941 SS=E		F 0941		

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F 0941 SS=E	Continued from page 78 483.95(a) Communication Training §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. This REQUIREMENT is not met as evidenced by:	F 0941	Employee's 3, 5, 6, 8 and 9 will receive the communication training in January 2026. All employees will receive an annual communication training during a set month of the year. Human Resource Director will educate all Department Directors on the annual education requirements for Communication training Human resource Director or designee will audit the training to assure all staff have been educated on training topic. Audit results will be turned into Quality Assurance meeting monthly.	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

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F 0941 SS=E	Continued from page 79 Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Effective Communication for five of seven staff members (Registered Nurse (RN) Employee E3, Nurse Aide (NA) Employees E5, E6, E8, and Licensed Practical Nurse (LPN Employee E9). Findings include: Review of facility policy "Training Requirements" dated 8/13/25, indicated that it is the policy of this facility to develop, implement and maintain an effective training program for all new and existing staff, individuals providing services under contractual arrangement, and volunteers, consistent with their expected roles. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program, Training requirements should be met prior to staff and volunteers independently providing services to residents,	F 0941		

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F 0941 SS=E	Continued from page 80 annually, and as necessary based on the facility assessment. Training content includes at a minimum Effective Communication. Review of RN Employee E3's personnel file indicated a hire date of 10/1/23, and failed to include Effective Communication training between 10/1/24, and 10/1/25. Review of NA Employee E5's personnel file indicated a hire date of 9/21/18, and failed to include Effective Communication training between 9/21/24, and 9/21/25. Review of NA Employee E6's personnel file indicated a hire date of 2/26/23, and failed to include Effective Communication training between 2/26/24, and 2/26/25. Review of NA Employee E8's personnel file indicated a hire date of 10/2/23, and failed to include Effective Communication training between 10/2/24, and 10/2/25.	F 0941		

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F 0941 SS=E	Continued from page 81 Review of LPN Employee E9's personnel file indicated a hire date of 5/24/23, and failed to include Effective Communication training between 5/24/24, and 5/24/25. During an interview on 12/9/25, at 1:59 p.m. Human Resources Employee E10 confirmed that the facility failed to provide training on Effective Communication for five of seven staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a) Staff Development.	F 0941		
F 0942 SS=E		F 0942		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395471	A. BLDG: 00 B. WING:	12/12/2025

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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F 0942 SS=E	Continued from page 82 483.95(b) Resident Rights Training §483.95(b) Resident's rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively. This REQUIREMENT is not met as evidenced by:	F 0942	Employee's 4, 5, 6, 7, 8 and 9 will receive the resident rights training in January 2026. All employees will receive an annual resident rights training during a set month of the year. Human Resource Director will educate all Department Directors on the annual education requirements for resident rights training Human resource Director or designee will audit the training to assure all staff have been educated on resident rights training topic. Audit results will be turned into Quality Assurance meeting monthly.	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0942 SS=E	Continued from page 83 Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Resident Rights for six of seven staff members (Nurse Aide (NA) Employee E4, NA Employee E5, NA Employee E6, NA Employee E7, NA Employee E8, and Licensed Practical Nurse (LPN) E9). Findings include: Review of facility policy "Training Requirements" dated 8/13/25, indicated that it is the policy of this facility to develop, implement and maintain an effective training program for all new and existing staff, individuals providing services under contractual arrangement, and volunteers, consistent with their expected roles. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program, Training requirements should be met prior to staff and volunteers independently providing services to residents,	F 0942		

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F 0942 SS=E	Continued from page 84 annually, and as necessary based on the facility assessment. Training content includes at a minimum Resident Rights. Review of NA Employee E4's personnel file indicated a hire date of 9/19/11, and failed to include Resident Rights training between 9/19/24, and 9/19/25. Review of NA Employee E5's personnel file indicated a hire date of 9/21/18, and failed to include Resident Rights training between 9/21/24, and 9/21/25. Review of NA Employee E6's personnel file indicated a hire date of 2/26/23, and failed to include Resident Rights training between 2/26/24, and 2/26/25. Review of NA Employee E7's personnel file indicated a hire date of 8/27/23, and failed to include Resident Rights training between 8/27/24, and 8/27/25.	F 0942		

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F 0942 SS=E	Continued from page 85 Review of NA Employee E8's personnel file indicated a hire date of 10/2/23, and failed to include Resident Rights training between 10/2/24, and 10/2/25. Review of LPN Employee E9's personnel file indicated a hire date of 5/24/23, and failed to include Resident Rights training between 5/24/24, and 5/24/25. During an interview on 12/9/25, at 12:59 p.m. Human Resources Employee E10 confirmed that the facility failed to provide training on ResidentRights for six of seven staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a) Staff development.	F 0942		
F 0943 SS=E		F 0943		

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F 0943 SS=E	Continued from page 86 483.95(c)(1)-(3) Abuse, Neglect, and Exploitation Training §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by:	F 0943	Employee's 5, 6, 8 and 9 will receive the Abuse and Neglect training in January 2026. All employees will receive an annual Abuse and Neglect training during a set month of the year. Human Resource Director will educate all Department Directors on the annual education requirements for abuse and neglect training Human resource Director or designee will audit the training to assure all staff have been educated on Abuse and Neglect training topic. Audit results will be turned into Quality Assurance meeting monthly.	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

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F 0943 SS=E	Continued from page 87 Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Abuse, Neglect, and Exploitation for four of seven staff members (Nurse Aide (NA) Employees E5, E6, and E8, and LicensedPractical Nurse (LPN) E9). Findings include: Review of facility policy "Training Requirements" dated 8/13/25, indicated that it is the policy of this facility to develop, implement and maintain an effective training program for all new and existing staff, individuals providing services under contractual arrangement, and volunteers, consistent with their expected roles. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program, Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility	F 0943		

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F 0943 SS=E	Continued from page 88 assessment. Training content includes at a minimum Abuse, Neglect, and Exploitation Prevention. Review of NA Employee E5's personnel file indicated a hire date of 9/21/18, and failed to include Abuse, Neglect, and Exploitation training between 9/21/24, and 9/21/25. Review of NA Employee E6's personnel file indicated a hire date of 2/26/23, and failed to include Abuse, Neglect, and Exploitation training between 2/26/24, and 2/26/25. Review of NA Employee E8's personnel file indicated a hire date of 10/2/23, and failed to include Abuse, Neglect, and Exploitation training between 10/2/24, and 10/2/25. Review of LPN Employee E9's personnel file indicated a hire date of 5/24/23, and failed to include Abuse, Neglect, and Exploitation trainingbetween 5/24/24, and 5/24/25.	F 0943		

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F 0943 SS=E	Continued from page 89 During an interview on 12/9/25, at 12:59 p.m. Human Resources Employee E10 confirmed that the facility failed to provide training on Abuse, Neglect, and Exploitation for four of seven staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a) Staff development.	F 0943		
F 0944 SS=E		F 0944		

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F 0944 SS=E	Continued from page 90 483.95(d) QAPI Training §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by:	F 0944	Employee's 5, 6, 8 and 9 will receive Quality Assurance and Performance Improvement training in January 2026. All employees will receive an annual Quality Assurance and Performance Improvement training during a set month of the year. Human Resource Director will educate all Department Directors on the annual education requirements for Quality Assurance and Performance Improvement training Human resource Director or designee will audit the training to assure all staff have been educated on Quality Assurance and Performance Improvement training topic. Audit results will be turned into Quality Assurance meeting monthly.	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

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F 0944 SS=E	Continued from page 91 Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on the Quality Assurance and Performance Improvement (QAPI) program for five of seven staff members (Registered Nurse (RN) Employee E3, Nurse Aide (NA) Employees E5, E6, and E8, and Licensed Practical Nurse (LPN) Employee E9). Findings include: Review of facility policy "Training Requirements" dated 8/13/25, indicated that it is the policy of this facility to develop, implement and maintain an effective training program for all new and existing staff, individuals providing services under contractual arrangement, and volunteers, consistent with their expected roles. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program, Training requirements should be met prior to staff and volunteers	F 0944		

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F 0944 SS=E	Continued from page 92 independently providing services to residents, annually, and as necessary based on the facility assessment. Training content includes at a minimum QAPI program. Review of RN Employee E3's personnel file indicated a hire date of 10/1/23, and failed to include QAPI training between 10/1/24, and 10/1/25. Review of NA Employee E5's personnel file indicated a hire date of 9/21/18, and failed to include QAPI training between 9/21/24, and 9/21/25. Review of NA Employee E6's personnel file indicated a hire date of 2/26/23, and failed to include QAPI training between 2/26/24, and 2/26/25. Review of NA Employee E8's personnel file indicated a hire date of 10/2/23, and failed to include QAPI training between 10/2/24, and	F 0944		

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F 0944 SS=E	Continued from page 93 10/2/25. Review of LPN Employee E9's personnel file indicated a hire date of 5/24/23, and failed to include QAPI training between 5/24/24, and 5/24/25. During an interview on 12/9/25, at 12:59 p.m. Human Resources Employee E10 confirmed that the facility failed to provide training on QAPI for five of seven staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a) Staff development.	F 0944		
F 0945 SS=E		F 0945		

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F 0945 SS=E	Continued from page 94 483.95(e) Infection Control Training §483.95(e) Infection control. A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at §483.80(a)(2). This REQUIREMENT is not met as evidenced by:	F 0945	Employee's 5, 6, 8 and 9 will receive the Infection Control training in January 2026. All employees will receive an annual Infection Control training during a set month of the year. Human Resource Director will educate all Department Directors on the annual education requirements for Infection Control training Human resource Director or designee will audit the training to assure all staff have been educated on Infection Control training topic. Audit results will be turned into Quality Assurance meeting monthly	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

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F 0945 SS=E	Continued from page 95 Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Infection Control for four of seven staff members (Nurse Aide (NA) Employees E5, E6, and E8, and Licensed Practical Nurse (LPN) Employee E9). Findings include: Review of facility policy "Training Requirements" dated 8/13/25, indicated that it is the policy of this facility to develop, implement and maintain an effective training program for all new and existing staff, individuals providing services under contractual arrangement, and volunteers, consistent with their expected roles. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program, Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility	F 0945		

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F 0945 SS=E	Continued from page 96 assessment. Training content includes at a minimum Infection Prevention, and Control Program. Review of NA Employee E5's personnel file indicated a hire date of 9/21/18, and failed to include Infection Control training between 9/21/24, and 9/21/25. Review of NA Employee E6's personnel file indicated a hire date of 2/26/23, and failed to include Infection Control training between 2/26/24, and 2/26/25. Review of NA Employee E8's personnel file indicated a hire date of 10/2/23, and failed to include Infection Control training between 10/2/24, and 10/2/25. Review of LPN Employee E9's personnel file indicated a hire date of 5/24/23, and failed to include Infection Control training between 5/24/24, and 5/24/25.	F 0945		

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F 0945 SS=E	Continued from page 97 During an interview on 12/9/25, at 12:59 p.m. Human Resources Employee E10 confirmed that the facility failed to provide training on Infection Control for four of seven staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a) Staff development.	F 0945		
F 0946 SS=E	483.95(f)(1)(2) Compliance and Ethics Training §483.95(f) Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at §483.85- §483.95(f)(1) An effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program. §483.95(f)(2) Annual training if the operating organization operates five or more facilities. This REQUIREMENT is not met as evidenced by:	F 0946	Employee's 3, 5, 6, and 8 will received the Compliance and Ethics training in January 2026. All employees will receive an annual Compliance and Ethics training during a set month of the year. Human Resource Director will educate all Department Directors on the annual education requirements for Compliance and Ethics training Human resource Director or designee will audit the training to assure all staff have been educated on Compliance and Ethics training topic. Audit results will be turned into Quality Assurance meeting monthly	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

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F 0946 SS=E	Continued from page 98 Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Compliance and Ethics for five of seven staff members (Registered Nurse (RN) Employee E3, Nurse Aide (NA) Employees E5, E6, and E8, and Licensed Practical Nurse (LPN) Employee E9). Findings include: Review of facility policy "Training Requirements" dated 8/13/25, indicated that it is the policy of this facility to develop, implement and maintain an effective training program for all new and existing staff, individuals providing services under contractual arrangement, and volunteers, consistent with their expected roles. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program, Training requirements should be met prior to staff and volunteers independently providing services to residents,	F 0946		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395471	A. BLDG: __00_____ B. WING: _____	12/12/2025

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F 0946 SS=E	Continued from page 99 annually, and as necessary based on the facility assessment. Training content includes at a minimum Compliance and Ethics Program. Review of RN Employee E3's personnel file indicated a hire date of 10/1/23, and failed to include Compliance and Ethics training between 10/1/24, and 10/1/25. Review of NA Employee E5's personnel file indicated a hire date of 9/21/18, and failed to include Compliance and Ethics trainingbetween 9/21/24, and 9/21/25. Review of NA Employee E6's personnel file indicated a hire date of 2/26/23, and failed to include Compliance and Ethics training between 2/26/24, and 2/26/25. Review of NA Employee E8's personnel file indicated a hire date of 10/2/23, and failed to include Compliance and Ethics training between 10/2/24, and 10/2/25.	F 0946		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0946 SS=E	Continued from page 100 Review of LPN Employee E9's personnel file indicated a hire date of 5/24/23, and failed to include Complianceand Ethics training between 5/24/24, and 5/24/25. During an interview on 12/9/25, at 12:59 p.m. Human Resources Employee E10 confirmed that the facility failed to provide training on Compliance and Ethics for five of seven staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a) Staff development.	F 0946		
F 0947 SS=E		F 0947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0947 SS=E	Continued from page 101 483.95(g)(1)-(4) Required In-Service Training for Nurse Aides §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:	F 0947	Employee's 5, 6, and 8 will receive their 12 hours of in-service training in January 2026. All Nurse Aides will receive their 12 hours of in-service training during a set month of the year. Human Resource Director will educate all Director of Nursing on the annual 12 hours of in-service for Nurse Aides. Human resource Director or designee will audit the training to ensure all nurse aides have been educated on the required topics for 12 hours of in-service annually Audit results will be turned into Quality Assurance meeting monthly	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

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F 0947 SS=E	Continued from page 102 Based on review of personnel records, and staff interview it was determined that the facility failed to ensure that three of five sampled Nurse Aides (NA) received a minimum of 12 hours of in-service education per year (NA Employees E5, E6, and E8). Findings include: Review of facility nurse aide training records revealed that NA Employee E5 did not receive 12 hours of in-service training in the last year. The facility was unable to provide documented evidence that NA Employee E5 had received a minimum of 12 hours of in-service training yearly. Review of facility nurse aide training records revealed that NA Employee E6 did not receive 12 hours of in-service training in the last year. The facility was unable to provide documented evidence that NA Employee E6 had received a	F 0947		

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F 0947 SS=E	Continued from page 103 minimum of 12 hours of in-service training yearly. Review of facility nurse aide training records revealed that NA Employee E8 did not receive 12 hours of in-service training in the last year. The facility was unable to provide documented evidence that NA Employee E8 had received a minimum of 12 hours of in-service training yearly. During an interview on 129/25, at 2:00 p.m. Human Resources Employee E10 confirmed that the facility did not have evidence that NA Employee E5, E6, and E8 received the required 12 hours of yearly in-service training 28 Pa. Code: 201.14(a) Responsibility of Licensee. 28 Pa. Code: 201.20(c) Staff Development.	F 0947		
F 0949 SS=E		F 0949		

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F 0949 SS=E	Continued from page 104 483.95(i) Behavioral Health Training §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.71. This REQUIREMENT is not met as evidenced by:	F 0949	Employee's 3, 5, 6, 8, and 9 will receive the Behavioral Health training in January 2026. All employees will receive an annual Behavioral Health training during a set month of the year. Human Resource Director will educate all Department Directors on the annual education requirements for Behavioral Health training Human resource Director or designee will audit the training to ensure all staff have been educated on Behavioral Health training topic. Audit results will be turned into Quality Assurance meeting monthly	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

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F 0949 SS=E	Continued from page 105 Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Behavioral Health for five of seven staff members (Registered Nurse (RN) Employee E3, Nurse Aide (NA) Employees E5, E6, and E8, and Licensed Practical Nurse (LPN) Employee E9). Findings include: Review of facility policy "Training Requirements" dated 8/13/25, indicated that it is the policy of this facility to develop, implement and maintain an effective training program for all new and existing staff, individuals providing services under contractual arrangement, and volunteers, consistent with their expected roles. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program, Training requirements should be met prior to staff and volunteers independently providing services to residents,	F 0949		

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F 0949 SS=E	Continued from page 106 annually, and as necessary based on the facility assessment. Training content includes at a minimum Behavioral Health. Review of RN Employee E3's personnel file indicated a hire date of 10/1/23, and failed to include Behavioral Health trainingbetween 10/1/24, and 10/1/25. Review of NA Employee E5's personnel file indicated a hire date of 9/21/18, and failed to include Behavioral Health training between 9/21/24, and 9/21/25. Review of NA Employee E6's personnel file indicated a hire date of 2/26/23, and failed to include Behavioral Health training between 2/26/24, and 2/26/25. Review of NA Employee E8's personnel file indicated a hire date of 10/2/23, and failed to include Behavioral Health trainingbetween 10/2/24, and 10/2/25.	F 0949		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0949 SS=E	Continued from page 107 Review of LPN Employee E9's personnel file indicated a hire date of 5/24/23, and failed to include Behavioral Health training between 5/24/24, and 5/24/25. During an interview on 12/9/25, at 12:59 p.m. Human Resources Employee E10 confirmed that the facility failed to provide Behavioral Health training on for five of seven staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a) Staff development.	F 0949		

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P 1020	Responsibility of licensee. (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other Federal, State and local agencies responsible for the health and welfare of residents. This includes complying with all applicable Federal and State laws, and rules, regulations and orders issued by the Department and other Federal, State or local agencies. This REGULATION is not met as evidenced by:	P 1020	Required signatures couldn't be obtained since meetings have passed. Infection preventionist will have the Medical Director, lab and pharmacy attend 1 meeting each quarter of the year. Director of Nursing or Designee will educate all team members of Invention Prevention on required meeting attendance. Director of Nursing or designee will audit the Infection Control meetings to assure all required attendance is met quarterly. Audit results will be turned into Quality Assurance meeting monthly	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/05/2026**

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

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P 1020	Continued from page 1 Based on facility policy, staff interview, and review of the facility's Infection Control Committee Meeting attendance records, it was determined that the facility failed to ensure that Infection Control meetings had all the required nine multidisciplinary members present at the Infection Control meetings for three of four quarters (Quarters One, Two, and Three). Findings include: Review of facility "Infection Prevention and Control Risk Assessment Procedure" policy dated 10/13/25, indicated the facility documents a risk assessment that utilizes an all-hazard approach. This risk assessment will be used for prioritizing activities of the facility's infection prevention and control program. During an interview on 12/8/25, the Director of Nursing stated that they have quarterly Infection Control Meetings.	P 1020		

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P 1020	Continued from page 2 Review of the facility's First Quarterly Infection Control Committee Meeting attendance log form dated 1/30/25, failed to reveal that the Medical Director, a lab representative, and a pharmacy representative were in attendance. Review of the facility's Second Quarterly Infection Control Committee Meeting attendance log form dated 7/24/25, failed to reveal that a lab and pharmacy representative were in attendance. Review of the facility's Third Quarterly Infection Control Committee Meeting attendance log form dated 9/25/25, failed to reveal that the Medical Director, a lab representative, and a pharmacy representative were in attendance. During an interview on 12/9/25, at 12:37 p.m. the Director of Nursing confirmed the facility failed to ensure that Infection Control meetings had all the required nine multidisciplinary members present at the Infection Control meetings for three of four quarters (Quarters One, Two, and Three).	P 1020		

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P 1020	Continued from page 3	P 1020		
P 1470	Personnel policies and procedures. (4) A determination by a health care practitioner that the employee, as of the employee's start date, is free from the communicable diseases or conditions listed in § 27.155 (relating to restrictions on health care practitioners). This REGULATION is not met as evidenced by:	P 1470	Employe 1 and 2 had their physical forms reviewed and signed by health care practitioners. Human Resource Director will make review the last 10 new hires physical form to verify they were signed prior to starting employment clearing them form communicable diseases. Director of Nursing or Designee will Human Resources on required physical form signed prior to starting employment clearing them form communicable diseases. Human Resources or designee will audit the New hire employee files to assure all required signatures are completed. Audit results will be turned into Quality Assurance meeting monthly	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

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P 1470	Continued from page 4 Based on review of employee personnel records and staff interview, it was determined that the facility failed to ensure personnel records included a determination by a health care practitioner that the employee, as of the employee's start date, is free from communicable disease or conditions for two of five personnel files reviewed (Dietary Aide Employee E1, and Nurse Aide (NA) Employee E2). Findings include: Review of Dietary Aide Employee E1's personnel file revealed that the start date of employment was 8/5/25. Review of Dietary Aide Employee E1's personnel file did not include documentation by a licensed practitioner (e.g., physician, nurse practitioner, physician's assistant) of verification that Dietary Aide Employee E1 was free from communicable disease or conditions. Health Form was signed only by Dietary Aide Employee E1.	P 1470		

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P 1470	Continued from page 5 Review of Nurse Aide (NA) Employee E2's personnel file revealed that the start date of employment was 8/22/25. Review of NA Employee E2's personnel file did not include documentation by a licensed practitioner (e.g., physician, nurse practitioner, physician's assistant) of verification that NA Employee E2 was free from communicable disease or conditions. Health Form was signed only by NA Employee E2. During an interview on 12/10/25, at 1:50 p.m. the Human Resource Employee E10 confirmed the facility failed to ensure personnel records included a determination by a health care practitioner that the employee, as of the employee's start date, is free from communicable disease for two of five personnel files reviewed (Dietary Aide Employee E1, andNurse Aide Employee E2).	P 1470		

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P 1550	Staff development. (1) Accident prevention. This REGULATION is not met as evidenced by:	P 1550	Employee's 4, 5, 6, 7, 8, and 9 will received the Accident Prevention training in January 2026. All employees will receive an annual Accident Prevention training during a set month of the year. Human Resource Director will educate all Department Directors on the annual education requirements for Accident Prevention training Human resource Director or designee will audit the training to assure all staff have been educated on Accident Prevention training topic. Audit results will be turned into Quality Assurance meeting monthly	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

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P 1550	Continued from page 7 Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Accident Prevention for six of seven staff members (Nurse Aide (NA) Employees E4, NA Employee E5, NA Employee E6, NA Employee E7, NA Employee E8, and Licensed Practical Nurse (LPN) Employee E9). Findings include: Review of facility policy "Training Requirements" dated 8/13/25, indicated that it is the policy of this facility to develop, implement and maintain an effective training program for all new and existing staff, individuals providing services under contractual arrangement, and volunteers, consistent with their expected roles. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program, Training requirements should be met prior to staff and volunteers independently providing services to residents,	P 1550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395471	A. BLDG: 00 B. WING:	12/12/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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P 1550	Continued from page 8 annually, and as necessary based on the facility assessment. Review of NA Employee E4's personnel file indicated a hire date of 9/19/11, and failed to include Accident Prevention training between 9/19/24, and 9/19/25. Review of NA Employee E5's personnel file indicated a hire date of 9/21/18, and failed to include Accident Prevention training between 9/21/24, and 9/21/25. Review of NA Employee E6's personnel file indicated a hire date of 2/26/23, and failed to include Accident Prevention training between 2/26/24, and 2/26/25. Review of NA Employee E7's personnel file indicated a hire date of 8/27/23, and failed to include Accident Prevention training between 8/27/24, and 8/27/25.	P 1550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 1550	Continued from page 9 Review of NA Employee E8's personnel file indicated a hire date of 10/2/23, and failed to include Accident Prevention training between 10/2/24, and 10/2/25. Review of LPN Employee E9's personnel file indicated a hire date of 5/24/23, and failed to include Accident Prevention training between 5/24/24, and 5/24/25. During an interview on 12/9/25, at 12:59 p.m. Human Resources Employee E10 confirmed that the facility failed to provide training on Accident Prevention for six of seven staff members as required.	P 1550		
P 1560		P 1560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 1560	Continued from page 10 Staff development. (2) Restorative nursing techniques. This REGULATION is not met as evidenced by:	P 1560	Employee's 3, 4, 5, 6, 7, 8, and 9 will receive the Restorative Nursing training in January 2026. All employees will receive an annual Restorative Nursing training during a set month of the year. Human Resource Director will educate all Department Directors on the annual education requirements for Restorative Nursing training Human Resource Director or designee will audit the training to assure all staff have been educated on Restorative Nursing training topic. Audit results will be turned into Quality Assurance meeting monthly	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 1560	Continued from page 11 Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Restorative Nursing for seven of seven staff members (Registered Nurse (RN) Employee E3, Nurse Aide (NA) Employee E4, NA Employee E5, NA Employee E6, NA Employee E7, NA Employee E8, and Licensed Practical Nurse (LPN) Employee E9). Findings include: Review of facility policy "Training Requirements" dated 8/13/25, indicated that it is the policy of this facility to develop, implement and maintain an effective training program for all new and existing staff, individuals providing services under contractual arrangement, and volunteers, consistent with their expected roles. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program, Training requirements should be met prior to staff and volunteers	P 1560		

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P 1560	Continued from page 12 independently providing services to residents, annually, and as necessary based on the facility assessment. Review of RN Employee E3's personnel file indicated a hire date of 10/1/23, and failed to include Restorative Nursing training between 10/1/24, and 10/1/25. Review of NA Employee E4's personnel file indicated a hire date of 9/19/11, and failed to include Restorative Nursing training between 9/19/24, and 9/19/25. Review of NA Employee E5's personnel file indicated a hire date of 9/21/18, and failed to include Restorative Nursing training between 9/21/24, and 9/21/25. Review of NA Employee E6's personnel file indicated a hire date of 2/26/23, and failed to include Restorative Nursing training between 2/26/24, and 2/26/25.	P 1560		

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P 1560	Continued from page 13 Review of NA Employee E7's personnel file indicated a hire date of 8/27/23, and failed to include Restorative Nursing training between 8/27/24, and 8/27/25. Review of NA Employee E8's personnel file indicated a hire date of 10/2/23, and failed to include Restorative Nursing training between 10/2/24, and 10/2/25. Review of LPN Employee E9's personnel file indicated a hire date of 5/24/23, and failed to include Restorative Nursing training between 5/24/24, and 5/24/25. During an interview on 12/9/25, at 1:59 p.m. Human Resources Employee E10 confirmed that the facility failed to provide training on Restorative Nursing for seven of seven staff members as required.	P 1560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 1570	Staff development. (3) Emergency preparedness in accordance with 42 CFR 483.73(d) (relating to emergency preparedness). This REGULATION is not met as evidenced by:	P 1570	Employee's 4, 5, 6, 7, 8, and 9 will receive the Emergency Preparedness training in January 2026. All employees will receive an annual Emergency Preparedness training during a set month of the year. Human Resource Director will educate all Department Directors on the annual education requirements for Emergency Preparedness training Human resource Director or designee will audit the training to assure all staff have been educated on Emergency Preparedness training topic. Audit results will be turned into Quality Assurance meeting monthly	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

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P 1570	Continued from page 15 Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Emergency Preparedness for six of seven staff members (Nurse Aide (NA) Employee E4, NA Employee E5, NA Employee E6, NA Employee E7, NA Employee E8, and Licensed Practical Nurse (LPN) Employee E9). Findings include: Review of facility policy "Training Requirements" dated 8/13/25, indicated that it is the policy of this facility to develop, implement and maintain an effective training program for all new and existing staff, individuals providing services under contractual arrangement, and volunteers, consistent with their expected roles. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program, Training requirements should be met prior to staff and volunteers	P 1570		

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P 1570	Continued from page 16 independently providing services to residents, annually, and as necessary based on the facility assessment. Review of NA Employee E4's personnel file indicated a hire date of 9/19/11, and failed to include Emergency Preparedness training between 9/19/24, and 9/19/25. Review of NA Employee E5's personnel file indicated a hire date of 9/21/18, and failed to include Emergency Preparedness training between 9/21/24, and 9/21/25. Review of NA Employee E6's personnel file indicated a hire date of 2/26/23, and failed to include Emergency Preparedness training between 2/26/24, and 2/26/25. Review of NA Employee E7's personnel file indicated a hire date of 8/27/23, and failed to include Emergency Preparedness training between 8/27/24, and 8/27/25.	P 1570		

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P 1570	Continued from page 17 Review of NA Employee E8's personnel file indicated a hire date of 10/2/23, and failed to include Emergency Preparedness training between 10/2/24, and 10/2/25. Review of LPN Employee E9's personnel file indicated a hire date of 5/24/23, and failed to include Emergency Preparedness training between 5/24/24, and 5/24/25. During an interview on 12/9/25, at 1:59 a.m. Human Resources Employee E10 confirmed that the facility failed to provide training on Emergency Preparedness for six of seven staff members as required.	P 1570		
P 1580		P 1580		

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P 1580	Continued from page 18 Staff development. (4) Fire prevention and safety in accordance with 42 CFR 483.90 (relating to physical environment). This REGULATION is not met as evidenced by:	P 1580	Employees 4, 5, 6, 7, 8, and 9 will receive the Fire Prevention training in January 2026. All employees will receive an annual Fire Prevention training during a set month of the year. Human Resource Director will educate all Department Directors on the annual education requirements for Fire Prevention training Human resource Director or designee will audit the training to assure all staff have been educated on Fire Prevention training topic. Audit results will be turned into Quality Assurance meeting monthly	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/04/2026**

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P 1580	Continued from page 19 Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Fire Prevention and Safety for six of seven staff members (Nurse Aide (NA) Employee E4, NA Employee E5, NA Employee E6, NA Employee E7, NA Employee E8, and Licensed Practical Nurse (LPN) Employee E9). Findings include: Review of facility policy "Training Requirements" dated 8/13/25, indicated that it is the policy of this facility to develop, implement and maintain an effective training program for all new and existing staff, individuals providing services under contractual arrangement, and volunteers, consistent with their expected roles. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program, Training requirements should be met prior to staff and volunteers	P 1580		

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P 1580	Continued from page 20 independently providing services to residents, annually, and as necessary based on the facility assessment. Review of NA Employee E4's personnel file indicated a hire date of 9/19/11, and failed to include Fire Prevention and Safety training between 9/19/24, and 9/19/25. Review of NA Employee E5's personnel file indicated a hire date of 9/21/18, and failed to include Fire Prevention and Safety training between 9/21/24, and 9/21/25. Review of NA Employee E6's personnel file indicated a hire date of 2/26/23, and failed to include Fire Prevention and Safety training between 2/26/24, and 2/26/25. Review of NA Employee E7's personnel file indicated a hire date of 8/27/23, and failed to include Fire Prevention and Safety training between 8/27/24, and 8/27/25.	P 1580		

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P 1580	Continued from page 21 Review of NA Employee E8's personnel file indicated a hire date of 10/2/23, and failed to include Fire Prevention and Safety training between 10/2/24, and 10/2/25. Review of LPN Employee E9's personnel file indicated a hire date of 5/24/23, and failed to include Fire Prevention and Safety training between 5/24/24, and 5/24/25. During an interview on 12/9/25, at 1:59 a.m. Human Resources Employee E10 confirmed that the facility failed to provide training on Fire Prevention and Safety for six of seven staff members as required.	P 1580		

Certified End Page

ARMSTRONG REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 530602

SURVEY EXIT DATE: 12/12/2025

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
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