STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395471	A. BLDG: __--_____ B. WING: _____	12/19/2025

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
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on December 18, 2025, it was determined that Armstrong Rehabilitation and Nursing Center had deficiencies that have the potential for minimal harm as related to the requirements of 42 CFR 483.73.	E 0000		
E 0036 SS=C		E 0036		

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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E 0036 SS=C	Continued from page 1 483.73(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be	E 0036	The systematic change will be an emergency Preparedness training will be held so all employees receive the required training for stated deficiency. The Administrator or designee will monitor the training to make sure it occurs and all employees have signed off receiving the training. An annual training will then be established so all employees received the Emergency Preparedness training required. Monthly Quality Assurance meeting will review training guidelines Education will be completed by January 31, 2026	Completion Date: **01/31/2026** Status: **APPROVED** Date: **12/30/2025**

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E 0036 SS=C	Continued from page 2 reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by:	E 0036		

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E 0036 SS=C	Continued from page 3 Based on document review and interview, the facility failed to provide annual emergency preparedness training to all staff and volunteers in one of one plan. Findings include: Document review on December 18, 2025, at 11:40 a.m., revealed the facility lacked documentation confirming all staff and volunteers had annual emergency preparedness training based on the facility's emergency preparedness plan. Interview with the administrator and maintenance supervisor on December 18, 2025, at 11:40 a.m., confirmed the facility lacked documentation confirming all staff and volunteers had annual emergency preparedness training based on the facility's emergency preparedness plan.	E 0036		

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E 0039 SS=C	483.73(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or	E 0039	The systematic change will be to have a Full scale exercise and training so the emergency plan can be tested and evaluated. The Administrator or designee will monitor the training to make sure it occurs and all employees have signed off receiving the training. Going forward a planned full scale exercise will be schedule with local emergency personnel so the emergency plan can be tested and evaluated. Monthly Quality Assurance meeting will review training guidelines The full scale exercise will be completed by January 31, 2026	Completion Date: **01/31/2026** Status: **APPROVED** Date: **12/30/2025**

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E 0039 SS=C	Continued from page 5 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:	E 0039		

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E 0039 SS=C	Continued from page 6 (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem	E 0039		

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E 0039 SS=C	Continued from page 7 statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a	E 0039		

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E 0039 SS=C	Continued from page 8 facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or	E 0039		

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E 0039 SS=C	Continued from page 9 (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based	E 0039		

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E 0039 SS=C	Continued from page 10 or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or	E 0039		

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E 0039 SS=C	Continued from page 11 an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may	E 0039		

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E 0039 SS=C	Continued from page 12 include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency	E 0039		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
E 0039 SS=C	Continued from page 13 events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by:	E 0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395471	A. BLDG: __--_____ B. WING: _____	12/19/2025

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E 0039 SS=C	Continued from page 14 Based on documentation review and interview, the facility failed to full-scale exercise, test, and evaluate one of one emergency plan. Findings include: Document review on December 18, 2025, at 11:45 a.m., revealed the facility lacked records to verify a plan to full scale exercise, test, and evaluate the emergency plan. Interview with the administrator and maintenance supervisor on December 18, 2025, at 11:45 a.m., confirmed the lack of documentation.	E 0039		

Certified End Page

ARMSTRONG REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 530602

SURVEY EXIT DATE: 12/19/2025

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

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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K 0000	INITIAL COMMENT Facility ID #530602 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on December 18-19, 2025, it was determined that Armstrong Rehabilitation and Nursing Center was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a five-story, Type II (222), fire resistive building, with a basement, that is fully sprinklered.	K 0000		
K 0100 SS=D		K 0100		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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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K 0100 SS=D	Continued from page 1 NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:	K 0100	The systematic change will be to get a copy of portable floor plans for the facility. A copy will be kept in Administrators office and Director of Maintenance Office. The Administrator will review annually portable copies with Director of maintenance to assure there's a complete set for use. Monthly Quality Assurance meeting will review Floor Plans	Completion Date: **01/31/2026** Status: **APPROVED** Date: **12/30/2025**

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K 0100 SS=D	Continued from page 2 Based on observation and interview, the facility failed to maintain general requirements of the Life Safety Code that are not addressed by specific K-tags, but are deficient, on one of six building levels. Findings include: Observation on December 19, 2025, at 11:00 a.m., revealed the facility failed to obtain required approval from the Department of Health State Plan Review and a granted occupancy from Life Safety Division for the change of use of resident rooms to storage rooms on the fifth floor. This is a repeat deficiency from the 2024 survey. The facility was unable to provide accurate floor plans to identify the fifth floor rooms as storage locations. Interview with the administrator and maintenance director on December 19, 2025, at 11:00 a.m., confirmed the facility did not submit the required paperwork.	K 0100		

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K 0100 SS=D	Continued from page 3 NFPA 1 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:	K 0100	The systematic change will be to get a copy of portable floor plans for the facility. A copy will be kept in Administrators office and Director of Maintenance Office. The Administrator will review annually portable copies with Director of maintenance to assure there's a complete set for use. Monthly Quality Assurance meeting will review Floor Plans	Completion Date: **01/31/2026** Status: **APPROVED** Date: **12/30/2025**

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K 0100 SS=D	Continued from page 4 Based on document review, observation, and interview, the facility failed to maintain portable floor plans that outlined designated rated partitions, affecting the entire facility. Findings include: Document review on December 18, 2025, at 9:05 a.m., revealed the facility failed to provide a set of accurate, portable floor plans. The Division of Safety Inspection is requiring that all facilities under its jurisdiction provide a portable, accurate floor plan on-site, to be used during the Life Safety Code Survey. The Life Safety Code Floor Plan shall include the following: a. Smoke barrier walls (outside wall to outside wall); b. Fire barrier walls (1-2 hour walls); c. Horizontal exits; d. Rated rooms (storage rooms, soiled utility	K 0100		

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K 0100 SS=D	Continued from page 5 rooms, designated medical gas rooms) will be clearly designated. It is the facility's responsibility to have all rated rooms indicated on its Life Safety Code Floor Plan; e. Required exits should be clearly noted; f. Shaft walls. Interview with the maintenance supervisor on December 18, 2025, at 9:05 a.m., confirmed the Life Safety Code Floor Plan provided during the survey failed to accurately contain the listed items.	K 0100		
K 0161 SS=F	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered	K 0161	The building structural assessment quote from February 27, 2025 will be reviewed with Regional team and vendor for availability for service completion. The Director of Maintenance will follow up once a date is confirmed that the work will be completed. Director of Maintenance will report to monthly Quality Assurance meeting of the progress of the work.	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/05/2026**

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K 0161 SS=F	Continued from page 6 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by:	K 0161		

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K 0161 SS=F	Continued from page 7 Based on document review and interview, the facility failed to maintain the building construction type, potentially affecting the structural integrity of one of one building. Findings include: Document review on December 18, 2025, at 9:45 a.m., revealed the facility failed to follow up on a building structural assessment quote provided by a vendor on February 27, 2025. The quote was obtained as part of the ongoing plan of correction from an initial survey completed on June 21, 2023. Interview with the maintenance supervisor on December 18, 2025, at 9:45 a.m., confirmed the facility did not follow-up on the building structural assessment quote.	K 0161		
K 0211 SS=C		K 0211		

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K 0211 SS=C	Continued from page 8 NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K 0211	The systematic change was removing the deadbolt lock after the surveyor left the building.Director of Maintenance will audit all office doors to assure there isn't a two-step locking mechanism in place. The Director of Maintenance will audit office doors for a two step lock and report findings to Monthly Quality Assurance meeting	Completion Date: **01/31/2026** Status: **APPROVED** Date: **12/30/2025**

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K 0211 SS=C	Continued from page 9 Based on observation and interview, the facility failed to meet means of egress requirements for one of over five office doors. Findings include: Observation on December 19, 2025, at 9:02 a.m. revealed on the first floor environmental services office next to the salon had a two-step lock, possibly slowing egress in the event of an emergency. Interview with the administrator and maintenance director on December 19, 2025, at 9:02 a.m., confirmed the dead bolt was on the door.	K 0211		
K 0225 SS=D		K 0225		

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K 0225 SS=D	Continued from page 10 NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by:	K 0225	The systematic change will be to have the retractable rope become a breakaway rope so not to impede progress through the stair tower door. The Director of Maintenance will audit all stairwell doors to assure there a retractable rope in place and report findings to Monthly Quality Assurance meeting	Completion Date: **01/31/2026** Status: **APPROVED** Date: **01/05/2026**

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K 0225 SS=D	Continued from page 11 Based on observation and interview, the facility failed to meet stairway enclosure requirements for two of five building levels. Findings include: Observation on December 19, 2025, at 9:01 a.m., revealed the stair tower doors had a caution retractable rope across keeping residents from exiting with the verbage "STOP!! DO NOT USE STAIRS ONLY FOR EMERGENCY." This could slow down residents in the event of an emergency. Interview with the maintenance director on December 19, 2025, at 9:01 a.m., confirmed the deficiency at the time of the survey.	K 0225		
K 0753 SS=D		K 0753		

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K 0753 SS=D	Continued from page 12 NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by:	K 0753	The systematic change will be to have the Christmas decorations that were in the hallway and covering doors be removed in total. The Administrator or designee will limit holiday materials in the hallway and doors and Administrator or designee will review holiday materials prior to placing them in facility	Completion Date: **01/31/2026** Status: **APPROVED** Date: **12/30/2025**

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K 0753 SS=D	Continued from page 13 Based on observation and interview, the facility failed to maintain combustible decorations on two of over five floors. Findings include: Observation on December 19, 2025, between 9:04 a.m. and 10:03 a.m., revealed the following combustible decoration deficiencies: A. (9:04 a.m.) First floor had combustible decorations plugged into the corridor, obstructing the egress full use pathway without fire retardant documentation available at the time of the survey; B. (10:03 a.m.) Second floor, fire and smoke door near the nurse station had santa banners pinned to the doors, obstructing the integrity of the door. Interview with the maintenance director on December 19 2025, at 10:03 a.m., confirmed the combustible decoration deficiencies.	K 0753		

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K 0918 SS=E	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918	The systematic change will be to contact vendor to get the unit main control board replaced. The Director of Maintenance will monitor service needs to generator and have vendor repair onsite as needed. The Director of Maintenance will report this findings to the Administrator and Monthly Quality Assurance meeting	Completion Date: **01/31/2026** Status: **APPROVED** Date: **12/30/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395471	A. BLDG: __01_____ B. WING: _____	12/19/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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K 0918 SS=E	Continued from page 15 Based on document review and interview, the facility failed to maintain the emergency generator for one of two generators. Findings include: Document review on December 18, 2025, at 10:14 a.m., revealed the annual planned maintenance inspection report for the 35 kW generator, dated March 13, 2025, noted "The unit main control board needs replaced to prevent possible no start." The facility lacked documentation that the item was corrected. Interview with the maintenance supervisor on December 18, 2025, at 10:14 a.m., confirmed the emergency generator deficiency.	K 0918		
K 0920 SS=D		K 0920		

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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K 0920 SS=D	Continued from page 16 NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:	K 0920	The systematic change was removing the three -to-one outlet immediately. The Director of Maintenance will monitor the beauty shop for appropriate use of electrical outlets.. The Director of Maintenance will report this findings to the Administrator and Monthly Quality Assurance meeting	Completion Date: **01/31/2026** Status: **APPROVED** Date: **12/30/2025**

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K 0920 SS=D	Continued from page 17 Based on observation and interview, the facility failed to meet electrical equipment requirements for one of over five corridor rooms. Findings include: Observation on December 19, 2025, at 8:30 a.m. revealed the first floor salon had a three-to-one outlet multiplier plugged into the wall with a hair dryer, hair straightener, and hair curler plugged into it. Interview with the maintenance director on December 19, 2025, at 8:30 a.m., confirmed the three-to-one outlet multiplier usage.	K 0920		
K 0923 SS=D		K 0923		

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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K 0923 SS=D	Continued from page 18 NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders	K 0923	The systematic change was removing the e-sized cylinders to make sure there were 12 or less in basement activity room. The Director of Maintenance will monitor the basement activity room for appropriate storage of E sized oxygen cylinders.. The Director of Maintenance will report this findings to the Administrator and Monthly Quality Assurance meeting	Completion Date: **01/31/2026** Status: **APPROVED** Date: **12/30/2025**

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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K 0923 SS=D	Continued from page 19 are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain oxygen storage on one of five building levels. Findings include: Observation on December 18, 2025, at 12:35 p.m., revealed the basement activities room had greater than 300 cubic feet of oxygen (over 12 e-sized cylinders) stored within the room. Interview with the maintenance supervisor on December 18, 2025, at 12:35 p.m., confirmed the oxygen storage deficiency.	K 0923		

Certified End Page

ARMSTRONG REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 530602

SURVEY EXIT DATE: 12/19/2025

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