



Certified End Page

PREMIER WASHINGTON REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 751102

SURVEY EXIT DATE: 04/15/2025

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


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395577	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025
NAME OF PROVIDER OR SUPPLIER: PREMIER WASHINGTON REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 36 OLD HICKORY RIDGE ROAD WASHINGTON, PA 15301		
STATE LICENSE NUMBER: 751102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0000	INITIAL COMMENT Facility ID# 751102 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on April 14-15, 2025, it was determined that Premier Washington 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 three-story, Type II (111), protected noncombustible building, with a basement, that is fully sprinklered.	K 0000		
K 0321 SS=D		K 0321		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

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

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395577	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: PREMIER WASHINGTON REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 751102	STREET ADDRESS, CITY, STATE, ZIP CODE: 36 OLD HICKORY RIDGE ROAD WASHINGTON, PA 15301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0321 SS=D	Continued from page 2 This REQUIREMENT is not met as evidenced by:	K 0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395577	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025	
NAME OF PROVIDER OR SUPPLIER: PREMIER WASHINGTON REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 751102		STREET ADDRESS, CITY, STATE, ZIP CODE: 36 OLD HICKORY RIDGE ROAD WASHINGTON, PA 15301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0321 SS=D	Continued from page 3 Based on observation and interview, it was determined the facility failed to maintain hazardous area enclosures in one instance, affecting 1 of 15 smoke compartments. Findings include: 1. Observation on April 14, 2025, at 11:30 a.m., revealed the door to a storage room, in the Inventory Control room, was secured open with a rope/string, and was unable to close and latch. Interview with the Assistant Facility Administrator and Maintenance Director on April 15, 2025, at 1:30 p.m., confirmed the listed hazardous area enclosure deficiency.	K 0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395577	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025
NAME OF PROVIDER OR SUPPLIER: PREMIER WASHINGTON REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 36 OLD HICKORY RIDGE ROAD WASHINGTON, PA 15301		
STATE LICENSE NUMBER: 751102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0321 SS=D	Continued from page 4	K 0321		
K 0353 SS=D		K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395577	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: PREMIER WASHINGTON REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 751102	STREET ADDRESS, CITY, STATE, ZIP CODE: 36 OLD HICKORY RIDGE ROAD WASHINGTON, PA 15301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0353 SS=D	Continued from page 5 NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	Large gap around two sprinkler pipes with escutcheons in the inventory control storage room. Ceiling hanger wire attached to sprinkler branch line above smoke door near 2 south supervisors office. Maintenance adjusted hanger in ceiling to raise the sprinkler head and escutcheon closer to the ceiling tile and replaced the ceiling tile. Maintenance removed hanger from sprinkler. Maintenance conducted audit of facility with no other issues with sprinklers or escutcheons The maintenance department will be educated on Sprinkler system compliance Audits will be completed by maintenance to ensure sprinkler system is in compliance, Weekly X4 weeks and monthly X 2. All audits will be reported to QAPI.	Completion Date: 05/28/2025 Status: APPROVED Date: 04/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395577	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025	
NAME OF PROVIDER OR SUPPLIER: PREMIER WASHINGTON REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 751102		STREET ADDRESS, CITY, STATE, ZIP CODE: 36 OLD HICKORY RIDGE ROAD WASHINGTON, PA 15301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0353 SS=D	Continued from page 6 Based on observation and interview, it was determined the facility failed to maintain the automatic sprinkler system in two instances, affecting two of 15 smoke compartments. Findings include: 1. Observation on April 14, 2025, revealed the following automatic sprinkler deficiencies: a) 9:25 a.m., there was a gap larger than 1/8 inch around two sprinkler heads with escutcheons, in a storage room inside the Inventory Control room; b) 9:55 a.m., there was ceiling tile track hangar wire attached to a sprinkler branch line, above the smoke doors near the 2 South Supervisor's office. Interview with the Assistant Facility Administrator and Maintenance Director on April 15, 2025, at 1:30 p.m., confirmed the automatic sprinkler system deficiencies.	K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395577	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025
NAME OF PROVIDER OR SUPPLIER: PREMIER WASHINGTON REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 36 OLD HICKORY RIDGE ROAD WASHINGTON, PA 15301		
STATE LICENSE NUMBER: 751102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0355 SS=D	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by:	K 0355	Inspection tag on the fire extinguisher in the 2 core breakroom did not have the annual inspection. Maintenance has ordered new fire extinguishers through Johnson Controls to be delivered. Maintenance conducted audit of all fire extinguishers in the facility with no other issues found Maintenance to be educated on compliance for all fire extinguishers Audits will be completed by maintenance to ensure all fire extinguishers are within compliance, Weekly X4 weeks and monthly X 2. All audits will be reported to QAPI.	Completion Date: 05/28/2025 Status: APPROVED Date: 04/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395577	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025
NAME OF PROVIDER OR SUPPLIER: PREMIER WASHINGTON REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 36 OLD HICKORY RIDGE ROAD WASHINGTON, PA 15301		
STATE LICENSE NUMBER: 751102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0355 SS=D	Continued from page 8 Based on observation and interview, it was determined the facility failed to maintain fire extinguishers in one instance, out of over 30 checked. Findings include: 1. Observation on April 14, 2025, at 10:20 a.m., revealed the inspection tag on the fire extinguisher in the 2 core staff break room did not have the annual inspection. Interview with the Facility Administrator and Maintenance Director on April 15, 2025, at 1:30 p.m., confirmed the portable fire extinguisher did not have the required annual inspection.	K 0355		
K 0911 SS=D		K 0911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395577	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025
NAME OF PROVIDER OR SUPPLIER: PREMIER WASHINGTON REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 36 OLD HICKORY RIDGE ROAD WASHINGTON, PA 15301		
STATE LICENSE NUMBER: 751102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0911 SS=D	Continued from page 9 NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0911	An open electrical junction box on the ceiling of the transfer switch room was identified. The cover for the box was immediately put back on Maintenance completed an audit throughout the facility with no other junction box issues The maintenance department will be educated to make sure all junction boxes are covered Audits will be completed by maintenance to ensure all junction boxes are covered, Weekly X4 weeks and monthly X 2. All audits will be reported to QAPI	Completion Date: 05/28/2025 Status: APPROVED Date: 04/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395577	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025
NAME OF PROVIDER OR SUPPLIER: PREMIER WASHINGTON REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 36 OLD HICKORY RIDGE ROAD WASHINGTON, PA 15301		
STATE LICENSE NUMBER: 751102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0911 SS=D	Continued from page 10 Based on observation and interview, it was determined the facility failed to maintain electrical wiring in one instance, in one of 15 smoke compartments. Installation shall be in accordance with <i>NFPA 70, National Electric Code</i> . 19.5.1.1, NFPA 101 (2012). Findings include: 1. Observation on April 14, 2025, at 10:17 a.m., revealed an open electrical junction box on the ceiling of the transfer switch room. Interview with the Facility Administrator and Maintenance Director on April 15, 2025, at 1:30 p.m., confirmed the open electrical junction box.	K 0911		
K 0920 SS=D		K 0920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395577	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025
NAME OF PROVIDER OR SUPPLIER: PREMIER WASHINGTON REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 36 OLD HICKORY RIDGE ROAD WASHINGTON, PA 15301		
STATE LICENSE NUMBER: 751102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0920 SS=D	Continued from page 11 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) assemblies 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	Appliances cited were removed from power strip to an appropriate outlet Maintenance completed audit with no other issues with power strips were identified in the facility Maintenance staff in serviced on what can and can't be plugged into a power strip. Audits will be completed by maintenance to ensure all power strips are used properly, Weekly X4 weeks and monthly X 2. All audits will be reported to QAPI	Completion Date: 05/28/2025 Status: APPROVED Date: 04/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395577	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025
NAME OF PROVIDER OR SUPPLIER: PREMIER WASHINGTON REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 36 OLD HICKORY RIDGE ROAD WASHINGTON, PA 15301		
STATE LICENSE NUMBER: 751102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0920 SS=D	Continued from page 12 Based on observation and interview, it was determined the facility failed to maintain electrical power cords and extension cords, affecting two of 15 smoke compartments. Findings include: 1. Observation on April 15, 2025, revealed the following electrical equipment deficiencies: a) 9:18 a.m., there was a microwave plugged into an extension cord in the second floor Supervisor's office; b) 9:35 a.m., there was a coffee pot and microwave plugged into a power strip in the Pharmacy break room.. Interview with the Assistant Facility Administrator and Maintenance Supervisor on April 15, 2025, at 1:30 p.m., confirmed the electrical power strip deficiencies.	K 0920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395577	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 04/15/2025
NAME OF PROVIDER OR SUPPLIER: PREMIER WASHINGTON REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE: 36 OLD HICKORY RIDGE ROAD WASHINGTON, PA 15301		
STATE LICENSE NUMBER: 751102					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE	
K 0920 SS=D	Continued from page 13	K 0920			



Certified End Page

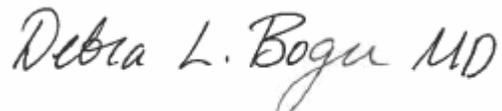
PREMIER WASHINGTON REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 751102

SURVEY EXIT DATE: 04/15/2025

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


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395577	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025
NAME OF PROVIDER OR SUPPLIER: PREMIER WASHINGTON REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 36 OLD HICKORY RIDGE ROAD WASHINGTON, PA 15301		
STATE LICENSE NUMBER: 751102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 751102 Component 02 West Wing - Alzheimer Unit</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on April 14-15, 2025, at Premier Washington Rehabilitation and Nursing Center, it was determined there were no deficiencies identified under the requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a one-story, Type II (000) unprotected noncombustible building, without a basement, that is fully sprinklered.</p>	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

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

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.



Certified End Page

PREMIER WASHINGTON REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 751102

SURVEY EXIT DATE: 04/15/2025

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


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395577	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025
NAME OF PROVIDER OR SUPPLIER: PREMIER WASHINGTON REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 36 OLD HICKORY RIDGE ROAD WASHINGTON, PA 15301		
STATE LICENSE NUMBER: 751102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0000	INITIAL COMMENT	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

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

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395577	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025	
NAME OF PROVIDER OR SUPPLIER: PREMIER WASHINGTON REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 751102		STREET ADDRESS, CITY, STATE, ZIP CODE: 36 OLD HICKORY RIDGE ROAD WASHINGTON, PA 15301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0000	Continued from page 1 Facility ID# 751102 Component 03 Activities Room Based on a Medicare/Medicaid Recertification Survey completed on April 14-15, 2025, at Premier Washington Rehabilitation and Nursing Center, it was determined there were no deficiencies identified under the 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 one-story, Type II (111) protected noncombustible building, without a basement, that is fully sprinklered.	K 0000		



Certified End Page

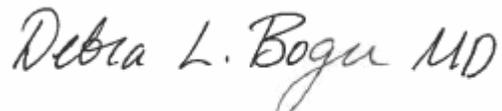
PREMIER WASHINGTON REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 751102

SURVEY EXIT DATE: 04/15/2025

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


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY