

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395577	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/27/2026
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
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on April 27, 2026, at Premier Washington Rehabilitation and Nursing Center, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

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

TITLE:

(X6) DATE:

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

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



Certified End Page

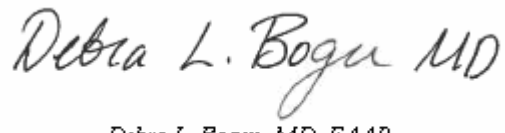
PREMIER WASHINGTON REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 751102

SURVEY EXIT DATE: 04/27/2026

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: 04/27/2026
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		
K 0353	<p>Facility ID# 751102 Component 01 Main Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on April 27-28, 2026, 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).</p> <p>This is a three-story, Type II (111), protected noncombustible building, with a basement, that is fully sprinklered.</p>	K 0353		
SS=E				

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: 04/27/2026
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 0353 SS=E	Continued from page 1 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	1. On April 27, 2026, the electrical MC wire conduit resting on the sprinkler piping above the ceiling tiles in the Elevator 4 Lobby on 3 East was removed and Elevator 4 Lobby on 2 East was removed and properly supported to eliminate contact with the sprinkler system piping. The Director of Maintenance verified that no damage occurred to the sprinkler piping or system 2. The Director of Maintenance conducted a facility-wide inspection above accessible ceiling spaces to identify any additional instances of electrical conduit, wiring, or other materials resting on sprinkler piping. Any additional findings identified during the inspection were immediately corrected at the time of discovery. 3. The Director of Maintenance educated maintenance department on requirements prohibiting any item from being supported by or resting on sprinkler piping.	Completion Date: 06/08/2026 Status: APPROVED Date: 05/11/2026

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: 04/27/2026
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 0353 SS=E	Continued from page 2	K 0353	4. The Director of Maintenance or designee will conduct weekly inspections x4 weeks and then monthly after, of a minimum of five random above-ceiling locations throughout the facility to verify compliance. Findings will be documented and reviewed during the facility's (QAPI) meetings monthly for three months	

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: 04/27/2026	
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=E	Continued from page 3 Based on observation, and interview, it was determined the facility failed to maintain the automatic sprinkler system in two instances, affecting two of fifteen smoke compartments. Findings include: 1. Observation on April 27, 2026, revealed the following automatic sprinkler deficiencies: a) 9:15 a.m., there was an electrical MC wire conduit resting on sprinkler lines above the ceiling tiles in the elevator 4 lobby on 3 East; b) 9:35 a.m., there was an electrical MC wire conduit resting on sprinkler lines above the ceiling tiles in the elevator 4 lobby on 2 East. Interview with the Facility Administrator and Director of Maintenance on April 28, 2026, at 1:00 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: 04/27/2026
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 0353 SS=E	Continued from page 4	K 0353		
K 0923 SS=E		K 0923		

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: 04/27/2026	
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 0923 SS=E	Continued from page 5 NFPA 101 Gas Equipment - Cylinder and Container Storage 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	<ol style="list-style-type: none"> On April 27, 2026, proper signage for oxygen was placed on the 3 east crash cart room and the 2 east crash cart room. On April 27th, 2026 the Director of Maintenance conducted a facility-wide inspection of all oxygen cylinder storage locations and crash cart rooms to verify that required oxygen signage was present and no oxygen cylinders were improperly stored. The maintenance staff were educated to ensure that proper signage for oxygen storage is posted for all rooms where oxygen is stored. The Director of Maintenance or designee will conduct weekly audits x4 weeks and monthly after for 3 months of oxygen storage areas to verify proper signage. Audit findings will be documented and reviewed during the facility's monthly QAPI meetings 	<p>Completion Date: 06/08/2026 Status: APPROVED Date: 05/11/2026</p>

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: 04/27/2026
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 0923 SS=E	Continued from page 6 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:	K 0923		

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: 04/27/2026
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 0923 SS=E	Continued from page 7 Based on observation and interview, it was determined the facility failed to properly store oxygen cylinders in two instances, affecting two of fifteen smoke compartments. Findings include: 1. Observation on April 27, 2026, revealed the following oxygen cylinder storage deficiencies: a) 10:13 a.m., there was an oxygen cylinder stored in the crash cart room in 3 East core without a sign indicating oxygen storage; b) 11:03 a.m., there was an oxygen cylinder stored in the crash cart room in 2 East core without a sign indicating oxygen storage. Interview with the Facility Administrator and Director of Maintenance on April 28, 2026, at 1:00 p.m., confirmed the doors did not have the proper signage.	K 0923		

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: 04/27/2026
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 0923 SS=E	Continued from page 8	K 0923		
K 0932 SS=D		K 0932		

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: 04/27/2026
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 0932 SS=D	Continued from page 9 NFPA 101 Features of Fire Protection - Other Features of Fire Protection - Other List in the REMARKS section any NFPA 99 Chapter 15 Features of Fire Protection 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 15 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0932	<ol style="list-style-type: none"> On April 28, 2026, the required warning signage indicating the room was equipped with an FM-200 extinguishing system was installed at the entrance to the affected room. The Director of Maintenance verified the signage was properly posted and visible in accordance with applicable Life Safety Code and NFPA requirements. On April 28, 2026, the Director of Maintenance conducted a facility-wide inspection of all rooms containing clean agent fire suppression systems, including FM-200 systems, to verify required warning signage was present. Any additional deficient areas identified during the inspection were corrected immediately. Maintenance staff were re-educated regarding NFPA requirements for identification and warning signage associated with clean agent extinguishing systems. The Director of Maintenance or 	Completion Date: 06/08/2026 Status: APPROVED Date: 05/11/2026

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: 04/27/2026
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 0932 SS=D	Continued from page 10	K 0932	designee will conduct monthly inspections for 3 months of all extinguishing system rooms to verify required signage remains in place and legible. Inspection findings will be documented and reviewed during the facility's (QAPI) meetings.	

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: 04/27/2026
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 0932 SS=D	Continued from page 11 Based on observation and interview, it was determined the facility failed to maintain the non-water-based fire protection system in one instance, affecting one of 15 smoke compartments. NFPA 99 (2012) 15.12.2. Findings include: 1. Observation on April 28, 2026 , at 11:40 a.m., revealed there was no warning sign indicating the room was equipped with a FM-200 extinguishing system. Interview with the Facility Administrator and Director of Maintenance on April 28, 2026, at 1:00 p.m., confirmed the above listed deficiency.	K 0932		



Certified End Page

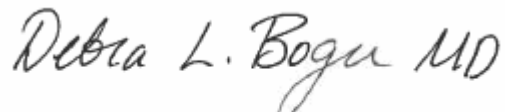
PREMIER WASHINGTON REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 751102

SURVEY EXIT DATE: 04/27/2026

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: 04/27/2026
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 27-28, 2026, 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

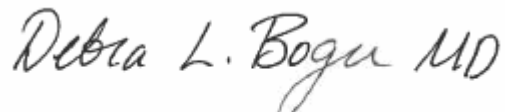
PREMIER WASHINGTON REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 751102

SURVEY EXIT DATE: 04/27/2026

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: 04/27/2026
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 03 Activities Room</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on April 27-28, 2026, 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 (111) protected 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

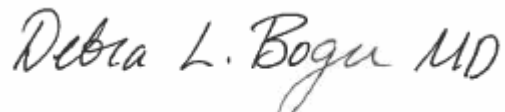
PREMIER WASHINGTON REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 751102

SURVEY EXIT DATE: 04/27/2026

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