STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395011	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Platinum Ridge Ctr for Rehab & Healing	1050 Broadview Boulevard Brackenridge, PA 15014

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of facility policy, Resident Council meeting minutes, and staff interviews, it was determined the facility failed to consider the views of a resident and act promptly on concerns and recommendations concerning issues of resident care and life in the facility for three of three months (December 2025, January 2026, and February 2026).Findings include:Review of the facility policy Resident Council dated 5/19/25, indicated the purpose of the resident council is to provide a forum for discussions of concerns and suggestions for improvement. All feedback and requests communicated from the resident council to the facility are addressed in writing to the council.Review of facility provided Resident Council Meeting Minutes dated 12/2/25, indicated:-Discussion of old/unfinished business: call bells not being answered timely.-Systemic concerns residents are concerned about the call bell audits. As a group, they feel that the wait times are too long, agency staff turn off call bells and do not enter rooms for assistance, and agency staff provide poor care on the weekends (call bells not answered and being on their phones instead of giving care).-Follow up: this section of the form was blank and failed to provide any follow up to the residents' concerns.Review of facility provided Resident Council Meeting Minutes dated 1/6/26, indicated:-Discussion of old/unfinished business: call bells not being answered timely.-The remainder of the form was blank and failed to provide any follow up to the residents' concerns.Review of facility provided Resident Council Meeting Minutes dated 2/3/26, indicated:-Discussion of old/unfinished business: No old business to discuss.-Systemic concerns residents expressed medications not being delivered timely.-Follow up: this section of the form was blank and failed to provide any follow up to the residents' concerns.During an interview on 2/23/26, at 3:00 p.m. the Nursing Home Administrator confirmed the facility failed to consider the views of a resident and act promptly on concerns and recommendations concerning issues of resident care and life in the facility for three of three months (December 2025, January 2026, and February 2026).28 Pa. Code: 201.18(e)(4) Management28 Pa. Code: 201.29(i) Resident Rights

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for three of four residents sampled with facility-initiated transfers (Resident R1, R2, and R3), and failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for three of four resident hospital transfers (Resident R1, R2, and R3).Findings include: Review of facility policy Transfer and Discharge Information dated 5/19/25, indicated when a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider. Review of facility policy Bed Holds and Return dated 5/19/25, indicated all residents or representatives are provided written information regarding the facility bed hold policies well in advance of any transfer (in the admission packet) and at the time of transfer. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/9/26, indicated diagnoses of atherosclerotic heart disease (build-up of fats, cholesterol, and other substances in and on the artery walls), chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), and dysphagia (difficult swallowing). Review of the clinical record indicated Resident R1 was transferred to the hospital on 2/20/26, and remains at the acute care hospital. Review of Resident R1's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R1's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 2/20/26. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS dated [DATE], indicated high blood pressure, depression, and muscle weakness. Review of the clinical record indicated Resident R2 was transferred to the hospital on 1/26/26, and returned to the facility on 1/26/26. Review of Resident R2's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R2's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 1/26/26. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS dated [DATE], indicated diagnoses of atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), high blood pressure, and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain).Review of the clinical record indicated Resident R3 was transferred to the hospital on 1/31/26, and returned to facility on 2/1/26. Review of Resident R3's clinical record revealed no documented evidence (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R3's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 1/31/26. During an interview on 2/23/24, at 1:53 p.m. the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for three of four residents sampled with facility-initiated transfers (Resident R1, R2, and R3), and failed to notify the resident or resident's representative of the facility bed-hold policy for three of four resident hospital transfers (Resident R1, R2, and R3). 28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews and staff interviews, it was determined that the facility failed to obtain laboratory results as ordered by the physician and failed to provide evidence that the physician or resident representative were notified of the results for two of three residents reviewed (Resident R3, and R4).Findings include: Review of facility policy Laboratory Services and Reporting dated 5/19/25, indicated the facility is responsible for the timeliness of the services and notifying the ordering physician of laboratory results that fall outside of the clinical reference range.Review of the facility policy Change in a Resident's Condition or Status dated 5/19/25, indicated the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the residents' medical/mental condition and/or status.Review of the admission record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's Minimum Data Set (MDS -a periodic assessment of care needs) dated 1/12/26, indicated diagnoses of stroke (damage to the brain from an interruption of blood supply), hemiplegia (paralysis of one side of the body), and urinary tract infection.Review of Resident R3's physician order dated 2/18/26, indicated to acquire a CMP (complete metabolic panel - a blood test that measures various substances in your blood to assess your overall health. Includes tests for: kidney function, liver function, blood sugar levels, electrolyte and fluid balance) in the morning for monitoring.There was no documented evidence in Resident 3's clinical record that staff obtained the results of the bloodwork and there was no documented evidence that the physician or resident representative were notified of the results.During an interview on 2/23/26, at 11:05 a.m., Licensed Practical Nurse (LPN) Employee E1 indicated, the lab results were not in the clinical record, and she did not have access to the computer system for the lab results, only the supervisor has access.Review of the admission record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's MDS dated [DATE], indicated diagnoses of anemia (the blood doesn't have enough healthy red blood cells), heart failure (heart doesn't pump blood as well as it should), and high blood pressure.Review of Resident R4's physician order dated 2/11/26, indicated to acquire a BMP (basic metabolic panel - a common blood test measuring eight key substances to assess kidney function, blood sugar, and electrolyte balance) one time only on 2/12/26.There was no documented evidence in Resident R4's clinical record that staff obtained the results of the bloodwork and there was no documented evidence that the physician or resident representative were notified of the results.During an interview on 2/23/26, at 10:30 a.m. with Resident R4's resident representative, it was indicated that Resident R4 had blood work a few weeks ago and nobody could tell the resident representative what the results were despite multiple inquiries made.During an interview on 2/23/26, at 11:05 a.m., LPN Employee E1 indicated, the lab results were not in the clinical record, and she did not have access to the computer system for the lab results, only the supervisor has access.During an interview on 2/23/26, at 3:00 p.m., the Director of Nursing confirmed that the facility failed to obtain laboratory results as ordered by the physician and failed to provide evidence that the physician or resident representative were notified of the results for two of three residents reviewed (Resident R3, and R4). 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.