STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395028	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Squirrel Hill Wellness and Rehabilitation Center	2025 Wightman Street Pittsburgh, PA 15217

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and documents, clinical record review and staff interviews, it was determined that the facility failed to provide adequate supervision to prevent a fall that resulted in the actual harm of a facial laceration that required sutures for one of three residents (Resident R1) This was identified as past noncompliance.Findings include:Review of facility policy, Safe Resident Handling dated 4/2/25, indicated The facility is to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote safe, secure, and comfortable experiences for the resident while keeping the employees safe in accordance with current standards and guidelines.Review of facility policy, Activities of Daily Living (ADLs) dated 4/2/25, indicated The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADL's do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; 2. Transfer and ambulation; 3. Toileting; 4. Eating to include meals and snacks; and 5. Using speech, language or other functional communication systems.Review of clinical record indicated Resident R1 was admitted to the facility on [DATE], and readmitted [DATE].Review of the Minimum Data Set (MDS- a periodic assessment of resident care needs) dated 7/29/25, included diagnoses of paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs), hemiplegia of right side (paralysis or weakness on one side of the body), cerebral vascular infarction (CVA-blood flow to the brain is interrupted, leading to brain tissue damage or death), Crohn's disease (chronic inflammatory bowel disease that affects the lining of the digestive tract).Review of the MDS dated [DATE], Section GG: Functional Abilities, Section GG0170- Subsection A, indicated Resident R1 to roll left and right, the ability to roll from lying on back to left or right side and return to lying on back on the bed is at substantial/maximal assistance.Review of Resident R1's plan of care for Alteration in function related to hemiplegia status post CVA and paraplegia dated 5/31/25, requires resident to have an assist of two for ADLs.Review of a progress note dated 9/15/25, at 4:32 p.m., indicated during bed change Resident R1 was rolled over on his side and was unable to stop rolling. He fell onto the floor hitting his forehead. When turned to assess it was observed a large (2-3 inch) laceration. Pressure applied to site and remaining assessment completed. Neuros within normal limits (WNL), no voiced pain, no other bruises or lacerations noted. MD notified and order given to transfer out to hospital. Made comfortable in place until EMT's arrived. OTH (out to hospital) via stretcher and EMT's. Two staff were present during this incident.Review of progress note dated 9/16/25, at 2:03 a.m. indicated Resident R1 returned at 2AM to the facility in stable condition. Head CT WNL (within normal limits). Forehead laceration repaired with sutures (6) to be removed in 7-10 days, follow-up with [hospital] Neurological Institute within 2 weeks. On 9/16/25, at 3:32 p.m. doctor called from the hospital stating, Resident R1 needs to return RE; abnormal x-rays, staff member and PA notified, sister notified, VSS, transfer via stretcher by 2 EMT's, paperwork in hand, transferred with cell phone. Note on 9/17/25, at 1:07 a.m. revealed all testing at the hospital negative for injuries related to the fall, the facility was advised to send the resident back due to an incidental finding of another medical issue and the resident was admitted to the hospital from [DATE], through 10/1/25.Review of facility incident report dated 9/15/25, indicated bedside care was being provided to Resident R1 on 9/15/25 at 1630, two Certified Nursing Assistants (CNA's). There was 1 CNA on each side of his bed. Bed mobility order: assist x2. During the bed change, resident was rolled over on his side and was unable to stop rolling. He fell onto the floor hitting his forehead. Resident is alert and oriented with a BIMS score of 14/15. A large (2-3 inch) laceration was observed on his forehead. Pressure applied to site and remaining assessment competed. Neuros WNL, no voiced pain, no other bruises or lacerations noted. MD notified and order given to transfer OTH. He was made comfortable in place until EMT's arrived. OTH via stretcher and EMT's.Review of Resident R1's plan of care for Resident at risk for falls related to immobility, hemiplegia at right side status-post CVA, included interventions initiated on 6/3/25 to educate the resident and family/caregivers about safety reminders and what to do if a fall occurs.Review of the document Caregiver Guide and Instructions for Safe Bed Mobility dated 9/16/25, provided by the Director of Nursing, revealed that forty staff members were educated on bed mobility and how to roll a resident from one side of the bed to the other for care. This education was confirmed with signatures of attendance and interviews.Review of CNA Employee E1's statement written on 9/15/25 indicated CNA Employee E1 and E2 was giving care on Resident R1 while resident was turned CNA