

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Squirrel Hill Wellness and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**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 notify a resident representative of a resident to resident abuse incident for one of four residents (Resident R1). Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2025, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aids in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of the facility policy, Abuse, Neglect, and Exploitation dated 2/14/25, indicated that it is the policy of the facility to provide protections for the health, welfare, and rights of each resident. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 8/12/25, included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles) and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Section C: Cognitive Patterns revealed a BIMS score of 07. Review of Resident R1's clinical record indicated that her child was her emergency contact and responsible party. Review of Resident R1's plan of care initiated 5/9/25, indicated Resident has an impaired mood status related to anxiety, dementia, admission to a skilled nursing facility, and a recent CVA (cardiovascular accident stroke). Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and dementia. Review of Section C: Cognitive Patterns revealed a BIMS score of 04. Review of Resident R2's clinical record indicated that her child was her emergency contact and responsible party. Review of Resident R2's plan of care initiated 10/14/25, indicated Resident R2 has behaviors of combativeness, resisting care, anxiety, and wandering. Review of a progress note dated 10/15/25, at 9:10 p.m. indicated, Resident (Resident R2) witnessed standing over roommate (Resident R1) stating I need to change you Roommate witnessed crying saying she's scared. Attempted to redirect pt (patient) when she became irate saying she is trying to work. Review of Resident R1's progress notes failed to reveal any documentation of the incident or notification to Resident R1's representative of the incident. Review of a progress note dated 11/4/25, at 11:13 a.m. indicated, Resident (Resident R2) observed standing over her roommate (Resident R1) who was in her bed yelling at her stating that she stole her belongings. Resident extremely difficult to redirect. Review of Resident R1's progress notes failed to reveal any documentation of the incident or notification to Resident R1's representative of the incident. During an interview on 12/5/25, at approximately 3:20 p.m. the Director of Nursing confirmed the facility failed to notify a resident representative of a resident to resident abuse incident for one of four residents. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(e)(1) Management.28 Pa. Code 201.29(a) Resident rights.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa Code 211.12(d)(1)(2)(5) Nursing services.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395028
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on a review of facility policy, nursing unit observations, and staff interviews, it was determined that the facility failed to provide a clean and homelike environment on one of four nursing units (Fourth Floor nursing unit). Findings include: Review of the facility policy, Safe and Homelike Environment dated 2/14/25, indicated, The facility will provide a safe, clean, comfortable, and homelike environment. During an observation of the Fourth Floor dining room/lounge on 12/5/25, at approximately 12:35 p.m. the sink was noted to have refuse in it, partially used bottles of shampoo and lotion were on a shelf above the sink, and a drawer had a broken handle. In the drawer was one sock, a soiled Ziploc bag, and a soiled disposable cup lid. The sink in the dining room/lounge only had a handle for hot water. The outlet on the wall next to the television had no faceplate, allowing access to the wires. In the lounge was a resident reclining chair with one arm cushion missing, exposing the metal frame. A brown substance was dried to the side of the chair, multiple substances appeared to have dried while dripping down the side, food residue was dried to the chair, and the reclining food rest was broken. During an observation on 12/5/25, at approximately 12:42 p.m. a restroom door (not designated as staff/visitor/resident) was unlocked and accessible to residents. No call light system was installed in the restroom. Personal hygiene items were noted to be stored on top of the paper towel dispenser. An interior door was noted to have silver duct tape covering the locking mechanism, not allowing it to engage. Upon opening the door, an electrical room was noted, allowing access to multiple circuit breakers and loose wires. During an interview on 12/5/25, at approximately 3:20 p.m., the Director of Nursing confirmed that the facility failed to provide a clean and homelike environment on one of four nursing units. 28 Pa. Code: 207.2(a) Administrator's responsibility. 28 Pa. Code: 201.29(k) Resident rights.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on a review of facility policy, observations, and staff interviews, it was determined that the facility failed to provide information regarding how to file a grievance and information on the grievance official on two of three nursing units (Fourth Floor and Fifth Floor) and failed provide and make accessible grievance forms to residents and visitors on three of three nursing units (Fourth Floor, Fifth Floor, and Sixth Floor). Review of the facility policy, Resident and Family Grievances dated 2/14/25, indicated, Notices of resident's rights regarding grievances will be posted in prominent locations throughout the facility. During an observation of the Fourth Floor nursing unit on 12/5/25, at approximately 1:55 p.m. the grievance box was not easily observed. During an interview on 12/5/25, at approximately 2:00 p.m. Licensed Practical Nurse (LPN) Employee E1 and Nurse Aide (NA) Employee E2 were unable to state where the grievance box was located on the unit. During an interview and observation on 12/5/25, at 2:04 p.m. NA Employee E3 was able to show the surveyor where the grievance box was. The grievance box was located in a vending machine room, attached to the wall. No words or signage were displayed to indicate that the box was for filing grievances. No grievance forms were available for resident and/or the representative to fill out. No information was posted to indicate the Grievance Official or the process for filing a grievance. During an observation on 12/5/25, at 2:07 p.m. the Fifth Floor grievance box was located in the resident dining room/lounge. The box was attached to the wall and labeled Grievance Box. No grievance forms were available for resident and/or the representative to fill out. No information was posted to indicate the Grievance Official or the process for filing a grievance. During an observation on 12/5/25, at 2:11 p.m. the Fifth Floor grievance box was located in the resident dining room/lounge. The box was attached to the wall. No words or signage were displayed to indicate that the box was for filing grievances. No grievance forms were available for resident and/or the representative to fill out. Posted in a separate area of the nursing unit, near the elevators, was information on the Grievance Official. During an interview on 12/5/25, at approximately 3:20 p.m. the Director of Nursing confirmed the facility failed to provide information regarding how to file a grievance and information on the grievance official on two of three nursing units and failed provide and make accessible grievance forms to residents and visitors on three of three nursing units.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**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 investigate a resident-to-resident abuse incident for one of four residents (Resident R1). Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2025, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aids in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of the facility policy, Abuse, Neglect, and Exploitation dated 2/14/25, indicated that an immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 8/12/25, included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles) and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Section C: Cognitive Patterns revealed a BIMS score of 07. Review of Resident R1's clinical record indicated that her child was her emergency contact and responsible party. Review of Resident R1's plan of care initiated 5/9/25, indicated Resident has an impaired mood status related to anxiety, dementia, admission to a skilled nursing facility, and a recent CVA (cardiovascular accident stroke). Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and dementia. Review of Section C: Cognitive Patterns revealed a BIMS score of 04. Review of Resident R2's clinical record indicated that her child was her emergency contact and responsible party. Review of Resident R2's plan of care initiated 10/14/25, indicated Resident R2 has behaviors of combativeness, resisting care, anxiety, and wandering. Review of a progress note dated 10/15/25, at 9:10 p.m. indicated, Resident (Resident R2) witnessed standing over roommate (Resident R1) stating I need to change you Roommate (Resident R1) witnessed crying saying she's scared. Attempted to redirect pt (patient) when she became irate saying she is trying to work. Review of Resident R1's progress notes failed to reveal any documentation of the incident or notification to Resident R1's representative of the incident. Further review of the clinical record failed to reveal any actions taken to prevent a recurrence of the incident or an offer to move the resident to a different room. Review of a progress note dated 11/4/25, at 11:13 a.m. indicated, Resident (Resident R2) observed standing over her roommate (Resident R1) who was in her bed yelling at her stating that she stole her belongings. Resident extremely difficult to redirect. Review of Resident R1's progress notes failed to reveal any documentation of the incident or notification to Resident R1's representative of the incident. Further review of the clinical record failed to reveal any actions taken to prevent a recurrence of the incident or an offer to move the resident to a different room. During an interview on 12/5/25, at approximately 12:00 p.m. the facility was asked to provide documentation of an investigation into the incidents on 10/15/25, and 11/4/25. The Director of Nursing confirmed that the facility did not complete an investigation into the incidents to prevent recurrence. During an interview on 12/5/25, at approximately 3:20 p.m. the Director of Nursing confirmed the facility failed to investigate a resident-to-resident abuse incident for one of four residents. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(e)(1) Management.28 Pa. Code 201.29(a) Resident rights.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa Code 211.12(d)(1)(2)(5) Nursing services.</p>		