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	01/08/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical records, incident investigations, and staff interviews, it was determined that the facility failed to ensure that residents are free from misappropriation of property for three of seven residents (Resident R1, R2, and R3).Findings include: Review of the facility policy Abuse, Neglect, & Exploitation dated 2/14/25, previously defined misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. 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 clinical record revealed that Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 12/15/25, included diagnoses of peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Section C revealed Resident R1's BIMS score to be 01. Review of a physician's order dated 3/11/25, indicated Resident R1 received lorazepam (Ativan, an anti-anxiety medication) 0.5 mg three times per day. Review of the clinical record revealed that Resident R2 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior) and an anxiety disorder. Review of Section C revealed Resident R2's BIMS score to be 15. Review of a physician's order dated 11/24/25, indicated Resident R2 received clonazepam (Klonopin, an anti-anxiety medication) 1.0 mg two times per day. Review of facility submitted documentation on 12/29/25, indicated that on 12/28/25, Two controlled substances were identified as missing/unaccounted for during routine narcotic count reconciliation. One tablet of Lorazepam 0.5 MG belonging to [Resident R1] and one tablet of Clonazepam 1 MG belonging to [Resident R2]. The discrepancy was discovered on 12/28/25. The nurse in charge of the medication cart was Licensed Practical Nurse (LPN) Employee E1. The medications had been stored in a secured/locked medication cart on the 6th floor of the facility. A review of narcotic count records and MAR (medication administration record) documentation identified a discrepancy in the recorded quantity. Facility leadership was notified, an investigation was initiated, and appropriate steps were taken to secure remaining controlled substances. [LPN Employee E1] was given a drug screen and sent home pending investigation. There is concern of two missing narcotics and a potential diversion concern. Review of documentation of a verbal statement dated 12/28/25, indicated, A verbal statement was obtained from LPN Employee E1 via telephone on 12/28/25, at 2pm regarding two narcotic discrepancies identified on the 6th floor medication carts. LPN Employee E1 stated, The count was wrong this morning when I counted with [LPN Employee E4]. When asked why she assumed responsibility (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for the medication cart despite the incorrect count, LPN Employee E1 stated, I forgot my reading glasses so I couldn't see. I didn't know the count was wrong. As part of the investigation into the narcotic discrepancies identified on the 6th floor medication carts, LPN Employee E1 was requested to submit a urine drug screen. Following the request LPN Employee E1 was instructed to leave the facility and was placed on suspension pending completion of the investigation. The urine drug screen result was negative. During a follow-up statement provided by LPN Employee E1 on 12/31/25, indicated, Error.On Sunday morning [DATE] I was counting off the cart with LPN Employee E2 not LPN Employee E3 when I did not have my reading glasses on and the Ativan and Klonopin was not the right count. Review of and employee statement written by LPN Employee E2 on 12/31/25, indicated, On the morning of Sunday, 12/28/25, I, LPN Employee E2, counted out the narcotic drawer with LPN Employee E1 who was coming in to work at 7am to relieve me after I worked the 11p-7a shift. When we counted the drawer, all counts matched perfectly to the records, there was no discrepancy whatsoever on paper and nothing was questioned verbally. Review of a facility provided investigation document stated, Two controlled substances were identified as missing during routine narcotic count reconciliation. The missing medications include one tablet of Lorazepam 0.5 mg prescribed to Resident R1 and one tablet of clonazepam 1 mg prescribed to Resident R2. The discrepancy was discovered on 12/28/25. At the time of discovery, the medication card was assigned to LPN Employee E1. The medications had been stored in a secured, locked medication card on the sixth floor of the facility. A review of narcotic count sheets revealed the discrepancy and the recorded quantities. Facility leadership was immediately notified, and investigation was initiated, and appropriate measures were taken to secure all remaining controlled substances. LPN Employee E1 was administered a drug screen and sent home pending the outcome of the investigation. The situation raised concerns for missing narcotics and potential diversion. Statements were obtained from LPN Employee E1and LPN Employee E2 who handed off the medication card to LPN Employee E1 at 7:00 a.m. on 12/28/25. Both nurses reported that the narcotic count was accurate at the time of shift change and then no discrepancies were noted. LPN Employee E1 stated that she was unaware of any issue with the narcotic count, noting that she did not have her reading glasses at the time. During the course of the investigation, a perpetrator was identified. On 1/3/26. Registered Nurse (RN) Employee E3 (the Assistant Director of Nursing) was found to be in possession of an extra set of medication cart keys. RN Employee E3 was working in the facility during the time frame of the identified discrepancy on 12/28/25. The keys are immediately suspended, and RN Employee E3 was suspended pending further investigation. Review of the clinical record revealed that Resident R3 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of cirrhosis (chronic damage leading to scarring and failure) of the liver and end stage renal disease (ESRD, an inability of the kidneys to filter the blood). Review of Section C revealed Resident R3's BIMS score to be 09. During an employee statement written by LPN Employee E1 on 12/31/25, indicated, On the morning of December 27 while counting off the cart there was a stack of cards with rubber bands around it. I asked [LPN Employee E4] what it was and he said they belong to [Resident R39] and never mentioned anything about any money, money was never seen or mentioned so there was never any money counted. Review of an employee statement written by LPN Employee E2 on 12/31/25, indicated, The last time this writer (LPN Employee E2) noticed [Resident R3's] money inside the narcotic drawer on the 6 north cart was Friday morning (12/26/25) between the hours of 7a-8:45a. The money was visible through the side of a clear plastic ziplock bag. The money was not counted, but a hundred dollar bill was clearly visible. When I noticed the money was no longer visible through the bag when I counted said drawer Saturday night (12/27/25) at 11 PM, I immediately notified the acting supervisor. Review of an (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	employee statement written by LPN Employee E4 on 1/1/26, indicated, On 12/27/25. I, [LPN Employee E4], advised [LPN Employee E1] that [Resident R3] had the following in the narc box on the sixth floor north hall: 1 wallet , a stack of different credit cards , and money totaling $145. I even picked up the bundle that was in a plastic bag with his name on it, and showed it to her just to make sure that she knew it was in that particular box. Review of facility submitted documentation on 12/29/25, indicated that on 12/28/25, Credit cards (2 debit cards, Access card, state ID, Aetna insurance cards) and cash ($145) belonging to [Resident R3] were being stored in a locked drawer of the medication cart located on the 6th floor of the facility. It was due to be taken to the business office the following business day but was being secured in the medication cart over the weekend. On 12/28/2025, it was reported that the resident's money was missing. LPN Employee E1 was in charge of the medication cart. The funds had previously been secured in the locked drawer, and there is concern regarding the loss or possible misappropriation of resident property. Review of a facility entered Report Form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property submitted on 1/7/25, included the information, During the course of the investigation, it was discovered that RN/ADON Employee E3 was in possession of a set of keys that provided access to the medication carts and locked narcotic drawers. RN/ADON Employee E3 was working in the facility at the time the money was reported missing. Due to more than one nurse having access to the locked narcotic drawer of the medication cart during the relevant timeframe, the investigation is inconclusive and cannot be substantiated or unsubstantiated. The missing funds in the amount of $145.00 will be reimbursed to the resident by the facility. During an interview on 1/8/25, at approximately 11:00 a.m. the Nursing Home Administrator confirmed that the facility failed to ensure that residents are free from misappropriation of property for three of seven residents. 28 Pa. Code: 211.12 (d)(1)(5) Nursing services. 28 Pa. Code: 201.29(j) Resident rights.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on a review of facility policy, clinical records, incident investigations, and staff interviews, it was determined that the facility failed to report a misappropriation of resident property 12 of 14 residents (Resident R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, and R14).Findings include: Review of the facility policy Abuse, Neglect, & Exploitation dated 2/14/25, indicated the facility will report all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, orb. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 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 During an interview on 12/31/25, at approximately 11:00 a.m. the following Individual Patient Controlled Substance Administration Record (narcotic sign-out sheets) were provided for view to the Director of Nursing (DON), and a physical copy of the narcotic sign-out sheets was provided to the Nursing Home Administrator on 12/31/25, at approximately 11:15 a.m. Resident R3's narcotic sign-out sheet indicated additional doses of hydromorphone (a narcotic pain medication) signed out on paper, and not documented in the electronic medical record MAR:12/23/25: 2 mg at 8:00 a.m.12/24/25: 2 mg at 8:00 a.m.12/26/25: 2 mg at 12:30 p.m.12/28/25: 2 mg at 2:00 p.m.12/29/25: 2 mg at 12:32 a.m.12/27/25: 2 mg at 11:00 a.m. Resident R4's narcotic sign-out sheet indicated additional doses of Tramadol (a narcotic pain medication) signed out on paper, and not documented in the electronic medical record MAR:12/17/25: 50 mg at 9:00 p.m.12/18/25: 50 mg at 8:00 p.m.12/19/25: 50 mg at 8:00 p.m.12/23/25: 50 mg at 5:21 p.m.12/24/25: 50 mg at 10:00 a.m.12/27/25: 50 mg at 11:00 a.m. Resident R5's narcotic sign-out sheet indicated additional doses of oxycodone (a narcotic pain medication) signed out on paper, and not documented in the electronic medical record MAR:12/25/25: 5 mg at 9:00 p.m.12/26/25: 5 mg at 9:00 p.m.12/28/25: 5 mg at 9:00 a.m.12/28/25: 5 mg at 9:00 p.m.Illegible entry.12/29/25: 5 mg at 9:00 p.m. Resident R6's narcotic sign-out sheet indicated additional doses of oxycodone signed out on paper, and not documented in the electronic medical record MAR:12/28/25: 5 mg written over illegibly.Three doses were signed out on 12/30/25, between 12:20 a.m. and 5:00 a.m. Resident R5's was scheduled to only have one dose at 1:00 a.m. Resident R7's narcotic sign-out sheet indicated additional doses of Tramadol signed out on paper, and not documented in the electronic medical record MAR:10/19/25: 25 mg at 9:50 a.m.10/28/25: 25 mg at 7:00 p.m. Resident R8's narcotic sign-out sheet indicated additional doses of Tramadol signed out on paper, and not documented in the electronic medical record MAR:9/16/25: 50 mg at 8:00 a.m.9/17/25: 50 mg at 2:00 p.m.9/18/25: 50 mg at 8:30 a.m.9/19/25: 50 mg at 6:30 p.m.9/20/25: 50 mg at 8:00 a.m. Resident R9's narcotic sign-out sheet indicated additional doses of Tramadol signed out on paper, and not documented in the electronic medical record MAR:12/17/25: marked as error, not cosigned by a second nurse.12/18/25: 50 mg at 8:00 a.m.12/18/25: 50 mg at 9:00 p.m.12/27/25: 50 mg at 9:00 a.m. Resident R10's narcotic sign-out sheet indicated a dose of Tramadol was signed out on paper, and not documented in the electronic medical record MAR on 12/27/25, at 9:00 a.m. Review of the physician's orders indicated the order for Tramadol was discontinued on 12/15/25. Resident R11's narcotic sign-out sheet indicated additional doses of alprazolam (Xanax, an anti-anxiety medication) signed out on paper, and not documented in the electronic medical record MAR:12/30/25: 1.0 mg at 2:00 p.m. (two 0.5 mg (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tablets). Resident R12's narcotic sign-out sheet indicated additional doses of oxycodone/acetaminophen (Tylenol) signed out on paper, and not documented in the electronic medical record MAR:12/22/25: 5-325 mg at 6:36 p.m.12/24/25: 5-325 mg at 8:00 p.m.12/25/25: 5-325 mg at 12:30 p.m.12/25/25: 5-325 mg at 8:34 p.m.12/26/25: 5-325 mg at illegible time12/26/25: 5-325 mg at 12:00 p.m.12/28/25: 5-325 mg at 8:00 p.m.12/29/25: 5-325 mg at illegible time12/29/25: 5-325 mg at 10:45 a.m.12/29/25: 5-325 mg at 7:00 p.m.12/30/25: 5-325 mg at 11:30 a.m. Resident R13's narcotic sign-out sheet indicated additional doses of oxycodone signed out on paper, and not documented in the electronic medical record MAR:(3) doses wasted on 12/25/25.12/25/25: 5 mg at 11:00 p.m.12/26/25: 5 mg at 3:00 a.m.12/26/25: 5 mg at 10:00 p.m.12/27/25: 5 mg at illegible time12/27/25: 5 mg at 9:00 a.m.12/27/25: 5 mg at 5:00 p.m.12/28/25: 5 mg at 8:00 a.m.12/29/25: 5 mg at 12:50 p.m.12/30/25: 5 mg at 11:45 a.m. Resident R14's narcotic sign-out sheet indicated additional doses of Tramadol signed out on paper, and not documented in the electronic medical record MAR:12/18/25: 100 mg at 9:30 p.m.12/20/25: 100 mg at 8:00 a.m. (order no longer active).12/20/25: 100 mg at 9:30 p.m. (order no longer active).12/23/25: 50 mg at 9:00 a.m. (order no longer active). Review of documentation submitted by the facility to the State Survey Agency failed to include reports of possible misappropriation for the above residents. During follow-up review of documentation submitted by the facility to the State Survey Agency indicated that on 1/4/25, information was submitted, On 01/03/2025, a discrepancy was identified in the narcotic inventory for resident [Resident R13], with 4 1/2 tablets of Oxycodone 5 mg unaccounted for. The prior documented count at 7AM was 29 1/2 tablets, with 25 1/2 tablets remaining at 10:15 AM. No medication was administered to [Resident R13]. Review of activity indicated that [Registered Nurse Employee E3] accessed the narcotic drawer of the medication cart shortly before the discrepancy was noted. During an interview on 1/8/25, at approximately 11:00 the Nursing Home Administrator confirmed the facility failed to implement policies and procedures to report possible misappropriation of resident property for 12 of 14 residents. 28 Pa. Code: 211.12 (d)(1)(5) Nursing services. 28 Pa. Code: 201.29(j) Resident rights.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical records, incident investigations, and staff interviews, it was determined that the facility failed to implement policies and procedures to investigate misappropriation of resident property for 12 of 20 residents (Resident R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, and R14).Findings include: Review of the facility policy Abuse, Neglect, & Exploitation dated 2/14/25, A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.B. Written procedures for investigations include:1. Identifying staff responsible for the investigation;2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence);3. Investigating different types of alleged violations;4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations;5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and6. Providing complete and thorough documentation of the investigation. 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 aides 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 clinical record revealed that Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 12/15/25, included diagnoses of peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Section C revealed Resident R1's BIMS score to be 01. Review of a physician's order dated 3/11/25, indicated Resident R1 received lorazepam (Ativan, an anti-anxiety medication) 0.5 mg three times per day. Review of the clinical record revealed that Resident R2 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior) and an anxiety disorder. Review of Section C revealed Resident R2's BIMS score to be 15. Review of a physician's order dated 11/24/25, indicated Resident R2 received clonazepam (Klonopin, an anti-anxiety medication) 1.0 mg two times per day. Review of facility submitted documentation on 12/29/25, indicated that on 12/28/25, Two controlled substances were identified as missing/unaccounted for during routine narcotic count reconciliation. One tablet of Lorazepam 0.5 MG belonging to [Resident R1] and one tablet of Clonazepam 1 MG belonging to [Resident R2]. The discrepancy was discovered on 12/28/25. The nurse in charge of the medication cart was Licensed Practical Nurse (LPN) Employee E1. The medications had been stored in a secured/locked medication cart on the 6th floor of the facility. A review of narcotic count records and MAR (medication administration record) documentation identified a discrepancy in the recorded quantity. Facility leadership was notified, an investigation was initiated, and appropriate steps were taken to secure remaining controlled substances. [LPN Employee E1] was given a drug screen and sent home pending investigation. There is concern of two missing narcotics and a potential diversion concern. Review of documentation of a verbal statement dated 12/28/25, indicated, A verbal statement was obtained from LPN Employee E1 via telephone on 12/28/25, at 2pm regarding two narcotic discrepancies identified on the 6th floor medication carts. LPN Employee E1 stated, The count was wrong this morning when I counted with [LPN Employee E4]. When asked why she assumed responsibility for the medication cart despite the incorrect count, LPN Employee E1 stated, I forgot my reading glasses so I couldn't see. I didn't know the count was wrong. As part of (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the investigation into the narcotic discrepancies identified on the 6th floor medication carts, LPN Employee E1 was requested to submit a urine drug screen. Following the request LPN Employee E1 was instructed to leave the facility and was placed on suspension pending completion of the investigation. The urine drug screen result was negative. During a follow-up statement provided by LPN Employee E1 on 12/31/25, indicated, Error.On Sunday morning [DATE] I was counting off the cart with LPN Employee E2 not LPN Employee E3 when I did not have my reading glasses on and the Ativan and Klonopin was not the right count. Review of and employee statement written by LPN Employee E2 on 12/31/25, indicated, On the morning of Sunday, 12/28/25, I, LPN Employee E2, counted out the narcotic drawer with LPN Employee E1 who was coming in to work at 7am to relieve me after I worked the 11p-7a shift. When we counted the drawer, all counts matched perfectly to the records, there was no discrepancy whatsoever on paper and nothing was questioned verbally. Review of a facility provided investigation document stated, Two controlled substances were identified as missing during routine narcotic count reconciliation. The missing medications include one tablet of Lorazepam 0.5 mg prescribed to Resident R1 and one tablet of clonazepam 1 mg prescribed to Resident R2. The discrepancy was discovered on 12/28/25. At the time of discovery, the medication card was assigned to LPN Employee E1. The medications had been stored in a secured, locked medication card on the sixth floor of the facility. A review of narcotic count sheets revealed the discrepancy and the recorded quantities. Facility leadership was immediately notified, and investigation was initiated, and appropriate measures were taken to secure all remaining controlled substances. LPN Employee E1 was administered a drug screen and sent home pending the outcome of the investigation. The situation raised concerns for missing narcotics and potential diversion. Statements were obtained from LPN Employee E1and LPN Employee E2 who handed off the medication card to LPN Employee E1 at 7:00 a.m. on 12/28/25. Both nurses reported that the narcotic count was accurate at the time of shift change and then no discrepancies were noted. LPN Employee E1 stated that she was unaware of any issue with the narcotic count, noting that she did not have her reading glasses at the time. During the course of the investigation, a perpetrator was identified. On 1/3/26. Registered Nurse (RN) Employee E3 (the Assistant Director of Nursing) was found to be in possession of an extra set of medication cart keys. RN Employee E3 was working in the facility during the time frame of the identified discrepancy on 12/28/25. The keys are immediately suspended, and RN Employee E3 was suspended pending further investigation. During an interview on 12/31/25, at approximately 11:00 a.m. the Director of Nursing (DON) provided a copy of the investigation into Resident R1 and Resident R2's missing medication. Review of the investigation documents failed to reveal if the possibility of misappropriation was investigated for any other residents. During this interview, the following Individual Patient Controlled Substance Administration Record (narcotic sign-out sheets) were provided for view to the Director of Nursing: Resident R3's narcotic sign-out sheet indicated additional doses of hydromorphone (a narcotic pain medication) signed out on paper, and not documented in the electronic medical record MAR:12/23/25: 2 mg at 8:00 a.m.12/24/25: 2 mg at 8:00 a.m.12/26/25: 2 mg at 12:30 p.m.12/28/25: 2 mg at 2:00 p.m.12/29/25: 2 mg at 12:32 a.m.12/27/25: 2 mg at 11:00 a.m. Resident R4's narcotic sign-out sheet indicated additional doses of Tramadol (a narcotic pain medication) signed out on paper, and not documented in the electronic medical record MAR:12/17/25: 50 mg at 9:00 p.m.12/18/25: 50 mg at 8:00 p.m.12/19/25: 50 mg at 8:00 p.m.12/23/25: 50 mg at 5:21 p.m.12/24/25: 50 mg at 10:00 a.m.12/27/25: 50 mg at 11:00 a.m. Resident R5's narcotic sign-out sheet indicated additional doses of oxycodone (a narcotic pain medication) signed out on paper, and not documented in the electronic medical record MAR:12/25/25: 5 mg at 9:00 p.m.12/26/25: 5 mg at 9:00 p.m.12/28/25: 5 mg at 9:00 a.m.12/28/25: 5 mg at 9:00 p.m.Illegible entry.12/29/25: 5 mg at 9:00 (continued on next page)

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	395028	A. Building B. Wing	01/08/2026

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m. Resident R6's narcotic sign-out sheet indicated additional doses of oxycodone signed out on paper, and not documented in the electronic medical record MAR:12/28/25: 5 mg written over illegibly.Three doses were signed out on 12/30/25, between 12:20 a.m. and 5:00 a.m. Resident R5's was scheduled to only have one dose at 1:00 a.m. Resident R7's narcotic sign-out sheet indicated additional doses of Tramadol signed out on paper, and not documented in the electronic medical record MAR:10/19/25: 25 mg at 9:50 a.m.10/28/25: 25 mg at 7:00 p.m. Resident R8's narcotic sign-out sheet indicated additional doses of Tramadol signed out on paper, and not documented in the electronic medical record MAR:9/16/25: 50 mg at 8:00 a.m.9/17/25: 50 mg at 2:00 p.m.9/18/25: 50 mg at 8:30 a.m.9/19/25: 50 mg at 6:30 p.m.9/20/25: 50 mg at 8:00 a.m. Resident R9's narcotic sign-out sheet indicated additional doses of Tramadol signed out on paper, and not documented in the electronic medical record MAR:12/17/25: marked as error, not cosigned by a second nurse.12/18/25: 50 mg at 8:00 a.m.12/18/25: 50 mg at 9:00 p.m.12/27/25: 50 mg at 9:00 a.m. Resident R10's narcotic sign-out sheet indicated a dose of Tramadol was signed out on paper, and not documented in the electronic medical record MAR on 12/27/25, at 9:00 a.m. Review of the physician's orders indicated the order for Tramadol was discontinued on 12/15/25. Resident R11's narcotic sign-out sheet indicated additional doses of alprazolam (Xanax, an anti-anxiety medication) signed out on paper, and not documented in the electronic medical record MAR:12/30/25: 1.0 mg at 2:00 p.m. (two 0.5 mg tablets). Resident R12's narcotic sign-out sheet indicated additional doses of oxycodone/acetaminophen (Tylenol) signed out on paper, and not documented in the electronic medical record MAR:12/22/25: 5-325 mg at 6:36 p.m.12/24/25: 5-325 mg at 8:00 p.m.12/25/25: 5-325 mg at 12:30 p.m.12/25/25: 5-325 mg at 8:34 p.m.12/26/25: 5-325 mg at illegible time12/26/25: 5-325 mg at 12:00 p.m.12/28/25: 5-325 mg at 8:00 p.m.12/29/25: 5-325 mg at illegible time12/29/25: 5-325 mg at 10:45 a.m.12/29/25: 5-325 mg at 7:00 p.m.12/30/25: 5-325 mg at 11:30 a.m. Resident R13's narcotic sign-out sheet indicated additional doses of oxycodone signed out on paper, and not documented in the electronic medical record MAR:(3) doses wasted on 12/25/25.12/25/25: 5 mg at 11:00 p.m.12/26/25: 5 mg at 3:00 a.m.12/26/25: 5 mg at 10:00 p.m.12/27/25: 5 mg at illegible time12/27/25: 5 mg at 9:00 a.m.12/27/25: 5 mg at 5:00 p.m.12/28/25: 5 mg at 8:00 a.m.12/29/25: 5 mg at 12:50 p.m.12/30/25: 5 mg at 11:45 a.m. Resident R14's narcotic sign-out sheet indicated additional doses of Tramadol signed out on paper, and not documented in the electronic medical record MAR:12/18/25: 100 mg at 9:30 p.m.12/20/25: 100 mg at 8:00 a.m. (order no longer active).12/20/25: 100 mg at 9:30 p.m. (order no longer active).12/23/25: 50 mg at 9:00 a.m. (order no longer active). During the interview on 12/31/25, at approximately 11:00 a.m. the DON confirmed that the investigation into misappropriation failed to include audits of other residents' medication records, narcotic sign-out sheets, or resident interviews to ascertain if the misappropriation included other residents. During an interview on 1/8/25, at approximately 11:00 a.m. the Nursing Home Administrator confirmed the facility failed to implement policies and procedures to investigate misappropriation of resident property for 12 of 20 residents. 28 Pa. Code: 211.12 (d)(1)(5) Nursing services. 28 Pa. Code: 201.29(j) Resident rights.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on review of facility provided documents and and staff interviews, it was determined that the facility failed to ensure residents' records are readily accessible to the State Survey Agency which caused a delay in the survey process for one of three residents (Resident R3).During an interview on 12/30/25, at approximately 1:30 p.m. the (former) Nursing Home Administrator was requested to provide the investigation documents related to the possible misappropriation of resident property for Resident R3.During an interview on 12/31/25, at approximately 11:30 a.m. the Director of Nursing was requested to provide the investigation documents related to the possible misappropriation of resident property for Resident R3.During a telephone interview on 1/2/26, at 1:05 p.m. the (former) Nursing Home Administrator was requested to provide the investigation documents related to the possible misappropriation of resident property for Resident R3.During an electronic communication on 1/5/26, at 10:43 a.m. the Director of Nursing was requested to provide the investigation documents related to the possible misappropriation of resident property for Resident R3.During an electronic communication on 1/7/26, at 10:08 a.m. the Director of Nursing was requested to provide the investigation documents related to the possible misappropriation of resident property for Resident R3.During an electronic communication on 1/7/25, at 5:46 p.m. the investigation documents related to the possible misappropriation of resident property for Resident R3 were received.During an interview on 1/8/26, at approximately 11:00 a.m. the Nursing Home Administrator confirmed the facility failed to ensure residents' records are readily accessible to the State Survey Agency which caused a delay in the survey process for one of three residents.28 Pa. Code: 211.5(f)(g)(h) Clinical records.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on a review of facility policy, observation, and staff interview, it was determined that the facility failed to ensure an environment free from the potential spread of infection for 27 of 41 residents (Resident R3, R4, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, R35, R36, R37, R38).Findings include: Review of the facility policy, Isolation - Notices of Transmission-Based Precautions dated 6/1/25, indicated, Notices will be used to alert personnel and visitors of transmission-based precautions, while protecting the privacy of the resident. Review of the Pennsylvania Department of Health Respiratory Virus Outbreak Toolkit dated 11/24/25, indicated, The LTCF (long-term care facility) should encourage masking of HCP (health care personnel), residents, and visitors during any respiratory virus outbreak. Masks help to prevent the spread of illness. This provides protection for the wearer (if using a fitted N95 or KN95) and protection for others (some surgical and N95/KN95). When a resident is suspected or confirmed to have a respiratory viral infection, additional precautions are needed to protect HCP during resident care. These precautions should be used in addition to standard precautions, source control, and proper hand hygiene. Proper institution of TBP (transmission-based precautions) includes placement in a private room, if available. The toolkit further stated that for SARS-CoV-2 (Covid-19) airborne, contact, and eye protection should be used, per the United States Department of Health and Human Services, Centers for Disease Control and Prevention, guidelines: Airborne Precautions indicated everyone must:Clean their hands, including before entering and when leaving the room.Put on a fit-tested N-95 or higher-level respirator before room entry.Remove respirator after exiting the room and closing the door.Door to room must remain closed.Contact Precautions indicated everyone must:Clean their hands, including before entering and when leaving the room.Put on gloves before room entry. Discard gloves before room exit.Put on gown before room entry. Discard gown before room exit.Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. Review of facility provided documentation on 12/20/25, revealed that 41 of the 109 current residents were being treated for active Covid-19 infections. During an observation on 12/30/25, at 2:11 p.m. the following was observed on the Five South nursing unit:Room door for Resident R15 and R16 was open. Both residents had active Covid-19 infections.Room door for Resident R17 and R18 was open. Both residents had active Covid-19 infections.Room door for Resident R4 and R19 was open.Room door for Resident R20 and R21 was open. Both residents had active Covid-19 infections.Room door for Resident R22 and R23 was open. Resident R23 had an active Covid-19 infection.Room door for Resident R24 was open. Resident R24 had an active Covid-19 infection. During the observation, Licensed Practical Nurse (LPN) Employee E5 noted the surveyor writing down rooms numbers and she began closing the room doors. During an interview and observation on 12/30/25, at 2:13 p.m. LPN Employee E5 confirmed that none of the three PPE (personal protective equipment) caddies located in the Five South nursing unit had N-95 masks available to staff who would choose to wear them. During an observation on 12/30/25, at approximately 2:37 p.m. the following room doors of Covid-19 positive residents were open on the Sixth Floor nursing unit, allowing airborne virus to spread.Resident R25 and R26.Resident R27 and R3.Resident R28 and R29.Resident R30 and R31.Resident R32. During an observation on 12/30/25, at approximately 2:40 p.m. the following room doors of Covid-19 positive residents were open on the Fifth Floor nursing unit, allowing airborne virus to spread.Resident R36 and R14.Resident R37 and R38.Resident R16. During an observation on 12/30/25, at approximately 2:45 p.m. the following room doors of Covid-19 positive residents were open Fourth Floor nursing unit, allowing airborne virus to spread.Resident R33 and R34.Resident R35. During an interview on 12/30/25, at approximately 3:00 p.m. the Nursing Home Administrator confirmed the facility (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	failed to ensure an environment free from the potential spread of infection for 27 of 41 residents. 28 Pa. code: 201.14(a) Responsibility of Licensee.28 Pa. Code: 201.18 (b)(1)(e)(1) Management.28 Pa. Code: 211.10(a)(d) Resident Care Policies.28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing Services.