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	06/09/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to provide a safe, clean, comfortable, and homelike environment on one of three nursing units (6th floor).Findings include:Review of the facility policy Safe and Homelike Environment dated 6/9/26, previously reviewed 2/14/25, indicated the facility will provide a safe, clean, comfortable, and homelike environment.During an observation on 6/6/26, beginning at 11:15 a.m., the following was identified:Medication cart unlocked, allowing unsafe access to residents.Large bag of soiled linen in the hallway open, with soiled linen falling out onto the floor.Bag of clothing on resident room floor, with clothing falling out onto the floor.Nightlight without a cover, allowing access to the bulb and wiring.Soiled linen on resident room floors (multiple rooms).Staff restroom unlocked, without call light functionality, allowing unsafe access to residents.A breakfast tray on the counter with fruit flies swarming above it, and used gloves on the tray and dirty dishes.A deli-meat sandwich in plastic wrapping on the counter, unrefrigerated. The date on the bag was 6/5/26.Shower room had used gloves on the floor in multiple areas, refuse in the shower area, paper towels on the floor, and the trash can was overflowing onto the floor.Souled utility room unlocked, allowing unsafe access to the residents. Within the soiled utility room were unlidded trash containers, bags of trash on the floor, multiple sharps containers, the hopper (specialized plumbing fixture used to safely dispose of human waste, biohazardous fluids, or other heavy clinical waste) half full with soiled water, and the linen chute open access door open. The opening of the linen chute was approximately two feet by two feet square. Review of grievances received by the facility from March 2026, through May 2026, revealed two grievances filed on behalf of residents relating to cleanliness of their rooms. During an interview on 6/9/26, at approximately 3:45 p.m., the Nursing Home Administrator confirmed that the facility failed to provide a safe, clean, comfortable, and homelike environment on one of three nursing units (6th floor).28 PA. Code 201.14(a) Responsibility of Licensee28 PA. Code 201.18(b) Management

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to implement procedures to ensure availability of prescribed medications for one of four residents (Residents R5).Findings include: Review of the facility policy Pharmacy Services dated 6/9/26, previously reviewed 2/14/25, indicated that the facility willprovide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. Review of the clinical record indicated Resident R4 was readmitted to the facility on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 3/22/26, included diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and vitreous hemorrhage (leakage of blood into the clear, gel-like substance that fills the space between the eye's lens and the retina). Review of a physician's order dated 4/1/26, discontinued on 5/6/26, indicated Resident R5 was to receive Humalog insulin (injectable medication to treat high blood sugar / diabetes) on a sliding scale at 2:00 a.m. daily. Review of the May 2026 medication administration record (MAR) failed to reveal documentation of a blood sugar check or administration of Humalog insulin on 5/4/26. Review of Resident R5's progress notes failed to reveal documentation of a reason for the omission. Review of a physician's order dated 5/9/26, (order entered into the electronic medical record 5/9/26, at 7:12 p.m.) reordered on 5/21/26, indicated Resident R5 was to receive Lantus insulin (injectable medication to treat high blood sugar / diabetes) four units at bedtime, scheduled for 9:00 p.m. Review of the May 2026 MAR failed to reveal documentation of administration of Lantus insulin on 5/9/26, at 9:00 p.m. The MAR was documented that the medication was withheld. Review of Resident R5's progress notes failed to reveal documentation of a reason for the medication to be held. Review of the May 2026 MAR failed to reveal documentation of administration of Lantus insulin on 5/24/26, at 9:00 p.m. Review of Resident R5's progress notes failed to reveal documentation of a reason for the omission. Review of a physician's order dated 5/9/26, (order entered into the electronic medical record 5/9/26, at 7:19 p.m.) discontinued on 5/21/26, indicated Resident R5 was to receive atorvastatin (medication to treat high cholesterol) 80 mg (milligrams) at bedtime, scheduled for 9:00 p.m. Review of the May 2026 MAR failed to reveal documentation of administration of atorvastatin on 5/9/26, at 9:00 p.m. The MAR was documented that the medication was withheld. Review of Resident R5's progress notes failed to reveal documentation of a reason for the medication to be held. Review of a physician's order dated 5/10/26, (order entered into the electronic medical record 5/9/26, at 7:21 p.m.) indicated Resident R5 was to receive Humalog insulin on a sliding scale at 5:00 a.m. daily. Review of the May 2026 MAR failed to reveal documentation of a blood sugar check or administration of Humalog insulin on 5/10/26. Review of Resident R5's progress notes failed to reveal documentation of a reason for the omission. Review of a physician's order dated 5/21/26, indicated Resident R5 was to receive brimonidine tartrate ophthalmic solution, one drop in the left eye three times per day for dry eyes, schedule at 8:00 a.m., 12:00 p.m., and 8:00 p.m. Review of the May 2026 MAR failed to reveal documentation of administration of brimonidine eyedrops on Sunday 5/24/26, at 8:00 a.m. and 12:00 p.m. and on Thursday 5/28/26, at 8:00 a.m. and 12:00 p.m. Review of Resident R5's progress notes failed to reveal documentation of a reason for the omissions. Review of a physician's order dated 5/23/26, indicated Resident R5 was to receive amlodipine (a medication to treat high blood pressure) 10 mg one time per day on Tuesday, Thursday, Saturday, and Sunday. Review of the May 2026 MAR failed to reveal documentation of administration of amlodipine on Sunday 5/24/26, at 9:00 a.m. and on Thursday 5/28/26, at 9:00 am. Review of Resident R5's progress notes failed to reveal documentation (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of a reason for the omissions. Review of a physician's order dated 5/23/26, indicated Resident R5 was to receive carvedilol (a medication to treat high blood pressure) 25 mg one time per day on Tuesday, Thursday, Saturday, and Sunday. Review of the May 2026 MAR failed to reveal documentation of administration of carvedilol on Sunday 5/24/26, at 9:00 a.m. Review of Resident R5's progress notes failed to reveal documentation of a reason for the omissions. Review of a physician's order dated 5/23/26, indicated Resident R5 was to receive isosorbide (a medication to chest pain) 30 mg one time per day on Tuesday, Thursday, Saturday, and Sunday. Review of the May 2026 MAR failed to reveal documentation of administration of isosorbide on Sunday 5/24/26, at 9:00 a.m. and on Thursday 5/28/26, at 9:00 am. Review of Resident R5's progress notes failed to reveal documentation of a reason for the omissions. Review of the facility provided inventory of medications included in the automatic dispensing system included Humalog, Lantus, amlodipine, atorvastatin, carvedilol, and isosorbide. Review of facility census information confirmed that Resident R5 was present in the facility during the times the medications were omitted. During an interview on 6/9/26, at approximately 3:45 p.m. the Nursing Home Administrator confirmed that the facility failed to implement procedures to ensure availability of prescribed medications for one of four residents. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility policies, observations, and staff interview, it determined the facility failed to maintain sanitary conditions in the Main Kitchen, which created the potential for food borne illness.Findings include:Review of the facility policy Sanitation Inspection dated 6/9/26, previously reviewed 2/14/25, indicated, All food service areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents.During an observation of the Main Kitchen tour on 6/6/26, at approximately 12:00 p.m., the following was identified:Fruit flies present above the food preparation areas.Storage shelves under food preparation counters had spilled food residue, boxes of dry goods on their sides with contents spilling out, disposable food service items not in wrappings.Food preparation counters had items placed haphazardly, cup lids, sweetener packets, coffee grounds spilled, open containers of beverages, wet boxes of gloves with loose gloves, trays of bowls, and other serving items.Observation of a plastic tray holding clean food service utensils at the tray line revealed collected water in the bottom of the container, visibly soiled with food waste.Main Kitchen floors were soiled with debris underneath the food preparation counters. Observation of the room corners revealed mouse droppings to be present. Multiple adhesive mouse traps were present in the Main Kitchen.The walls of the Main Kitchen were noted to have food waste adhered to them, particularly close to the floor.Observation of the ice machine drain revealed it to be extremely soiled with cup lids and other refuse around it and the floor very soiled. Observation of the coffee machine revealed ripped paper and multiple spills of liquid dried to the counter surface.Review of the storage shelves revealed large bowls and pans not inverted allowing the collection of water and debris.Observation of a clear plastic container labeled flour revealed dates of 6/20/25, and 9/20/25, to be written on pieces of tape affixed to the container. The container was loosely cover with clear plastic wrap. Visible areas of dried liquid were present on the plastic wrap.Observation the walk-in freezer revealed packages of food to be spilled on the floor and the floor soiled with food residue.Observation of the dishroom revealed food waste, disposable food items, and other debris on the floor, with no delineation from the soiled side to the clean side.Observation of the racks for clean utensil and dish storage revealed refuse under the racks.Observation of the food service workers revealed three of the four employees present during the Main Kitchen observation to have no hair coverings on.During an interview on 6/9/26, at approximately 3:45 p.m. the Nursing Home Administrator the facility failed to maintain sanitary conditions in the Main Kitchen, which created the potential for food borne illness.28 Pa Code: 211.6(c)(d)(f) Dietary services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 policy and clinical records and staff interviews it was determined that the facility failed to make certain controlled substances were documented accurately for four of six residents (Resident R1, R2, R3, and R4).Findings include: The facility policy Medication Administration dated 6/9/26, previously reviewed 2/14/25, indicated Sign MAR (medication administration record) after administered. If medication is a controlled substance, sign narcotic book. Review of Resident R1's MAR (medication administration record) for May and June 2026, revealed an order for oxycodone 10mg (a narcotic pain medication used to treat moderate to severe pain) to be given every four hours as needed for severe pain. Twenty-six administrations were documented on the MAR from 5/31/26, through 6/5/26. Review of Resident R1's Controlled Drug Record indicated that eleven additional doses of oxycodone were signed out without corresponding documentation of administration to the resident on 6/1/26, 6/2/26 x two doses, 6/3/26 x two doses, 6/4/26 x two doses, 6/5/26 x three doses, and 6/6/26. Review of Resident R2's MAR for May and June 2026, revealed an order for oxycodone 5mg to be given every six hours as needed for pain. Fourteen administrations were documented from 5/25/26, through 6/5/26. Review of Resident R2's Controlled Drug Record indicated that eight additional doses of oxycodone were signed out without corresponding documentation of administration to the resident on 5/26/26, 5/28/26, 5/29/26 x three doses, 6/1/26, 6/3/26, and 6/4/26. Review of Resident R3's MAR for June 2026, revealed an order for oxycodone 5mg to be given every four hours as needed for severe pain. Zero administrations were documented from 6/1/26, through 6/5/26. Review of Resident R3's Controlled Drug Record indicated that two doses of oxycodone were signed out without corresponding documentation of administration to the resident on 6/2/26, and 6/4/26. Review of Resident R4's MAR for May 2026, revealed an order for Tramadol 50mg (an opioid pain medication used to treat moderate to severe pain) to be given every twelve hours as needed. Eleven administrations were documented on the MAR from 5/12/26, through 5/31/26. Review of Resident R4's Controlled Drug Record indicated that seven additional doses of oxycodone were signed out without corresponding documentation of administration to the resident on 5/15/26, 5/16/26, 5/17/27, 5/19/26, 5/20/26, 5/21/26, and 5/31/26. During an interview on 6/9/26, at approximately 3:45 p.m. the Nursing Home Administrator confirmed that the facility failed to make certain controlled substances were accounted for accurately for four of six residents. 28 Pa. Code: 211.9(a)(1)(j) Pharmacy services.28 Pa. Code: 211.12(d)(1)(5) Nursing services.