

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/31/2026
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of facility policy, clinical records, observations, and resident and staff interviews, it was determined that the facility failed to make certain residents were provided necessary treatments and services, consistent with professional standards of practice, to treat and/or prevent pressure ulcers (PU/PI - injuries to the skin and underlying tissues resulting from prolonged pressure on the skin) for four of seven residents (Resident R1, R2, R3, and R4). Findings include: Review of the facility policy, Prevention of Pressure Ulcers/Injuries dated 7/13/26, previously dated 2/14/25, indicated the Facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. 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 care needs) dated 6/25/26, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Section M: Skin Conditions indicated Resident R1 did not have a pressure ulcer at the time of the assessment. Review of a Predicting Pressure Ulcer Risk Evaluation dated 6/25/26, indicated Resident R1 was at very high risk for the development of pressure ulcers. Review of the plan of care for Potential or actual skin impairment revised on 4/2/26, indicated for staff to administer treatments as ordered and monitor for effectiveness and to follow facility policies/protocols for the prevention/treatment of skin breakdown. Further review of the care plan failed to reveal information on the use of bunny boots. Review of a physician's order dated 7/23/26, indicated Offloading boots to bilateral foot/heels while in bed. every shift for skin integrity. Review of the Treatment Administration Record (TAR) indicated that this was in informational order for licensed nurses. Review of Resident R1's Kardex (document that outlines the patients' ADLs, continence levels, and behaviors, as well as physician, advanced directives, diet, and allergies) utilized by nurse aide staff indicated instruction to assist Resident R1 with her bunny boots was not included until 7/30/26. Review of a practitioner progress note dated 7/22/26, at 8:14 p.m. indicated Resident R1 was seen per facility request to evaluation Resident R1's heels. Staff report that patient has been complaining of pain of her heels. The note indicated, the skin has identifiable open wound/breakdown; blanching discoloration. The note recommendations included side to side offloading while in bed and to Offload heels per facility protocol. Review of a progress note dated 7/30/26, at 12:31 p.m. indicated, Facility wound nurse conducted a skin check on resident. Resident had been c/o (complaining of) heel discomfort. Bilateral bunny boots (cushioned foot and heel protectors to prevent and treat pressure ulcers) order was already in place due to boggy heels (an early sign of a pressure injury where the skin feels soft, mushy, or spongy instead of firm). Resident was not wearing bunny boots. Heels checked. Resident right heel still boggy. Resident left (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	heel DTI's (deep tissue injury: persistent non-blanchable deep red, maroon or purple discoloration) measuring 1.3x1.3x0 (centimeters). Order for skin prep placed. Care provided. Bunny boots placed. No other wounds or skin issues present. During an interview on 7/31/26, at 10:10 a.m. Wound Care Nurse Employee E1 confirmed that Resident R1 began complaining of heel pain a couple weeks ago. During wound rounds with the wound practitioner and herself, Resident R1's heels were found to be soft, and an order was placed for Resident R1 to wear bunny boots while in bed. Wound Care Nurse Employee E1 stated during wound rounds on 7/30/26, Resident R1 was found to have a DTI. Wound Care Nurse Employee E1 stated that on 7/30/26, she added a viewable task for the nurse aides to inform them of the need for Resident R1 to have bunny boots on while in bed. 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 and chronic kidney disease (gradual loss of kidney function). Review of Section M: Skin Conditions indicated Resident R2 had an unstageable pressure ulcer at the time of the assessment. Review of a Predicting Pressure Ulcer Risk Evaluation dated 5/22/26, indicated Resident R2 was at moderate risk for the development of pressure ulcers. Review of the plan of care for Potential for or has impaired skin integrity revised on 7/21/26, indicated, The resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested. Review of physician's order dated 7/14/26, indicated Resident R2 is to wear bunny boots to bilateral heels at all times while in bed and to turn and reposition every two hours. Review of Resident R2's Kardex, as of 7/30/26, failed to include instruction for staff to assist Resident R2 with his bunny boots. During an interview and observation on 7/31/26, at approximately 11:20 a.m. Resident R2 was observed laying in bed on his back. Resident R2 had slid so low in the bed that Resident R2's heels were directly atop the wooden footboard that had a width of approximately one inch. At this time, Resident R2 said his heels hurt like hell. The surveyor requested staffs to assist Resident R2 to be pulled up in bed. Resident R2 stated to the surveyor, Thanks. I've been asking since 9:30. During a second observation on 7/31/26, at approximately 1:30 p.m., Resident R2 was observed to still be positioned on his back. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes and hemiplegia (paralysis on one side of the body) following a stroke. Review of Section G: Functional Abilities indicated Resident R3 is totally dependent on staff to assist him to roll left and right in bed. Review of Section M: Skin Conditions indicated Resident R3 had one Stage 3 pressure injury (full-thickness skin loss), one Stage 4 pressure injury (full-thickness skin and tissue loss) and three deep tissue pressure injuries (persistent non-blanchable deep red, maroon or purple discolorations) at the time of the assessment. Review of a Predicting Pressure Ulcer Risk Evaluation dated 6/18/26, indicated Resident R3 was at high risk for the development of pressure ulcers. Review of the plan of care for Resident has impaired skin integrity revised on 6/29/26, indicated, encourage/assist as needed to elevate heels off the mattress as tolerated and Assist resident with turning and repositioning as needed. Review of physician's order dated 6/18/26, indicated Resident R3 is to Float heels while in bed; bunny boots on at all times. Review of Resident R3's Kardex, as of 7/30/26, indicated for staff to assist Resident R3 to elevate his heels off the mattress as tolerated. Further review failed to include instruction for staff to assist Resident R3 with his bunny boots. Review of a progress note dated 7/27/26, at 2:50 p.m. indicated Resident R3 had a Stage 3 pressure injury to his left great toe and a Stage 4 pressure injury on his sacrum (lower back, below the waistline). During an observation on 7/31/26, at approximately 11:20 a.m. Resident R3 was observed laying in bed on his back. Resident R3 had slid so low in the bed that Resident R3's left foot (with a bandage on the left great toe) pressed directly against the footboard. A bunny boot was present only on Resident R3's right foot. When during the above request for staff to (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reposition Resident R2, after doing so, the staff walked past the bed of Resident R3 and did not assist him to relieve pressure on his foot. During a second observation on 7/31/26, at approximately 1:30 p.m., Resident R3 was observed to still be positioned on his back. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of the facility diagnosis list included diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), muscle wasting, and a leg fracture. Review of a progress note dated 7/24/26, at 7:40 a.m. indicated, Bilateral heels appear to have DTIs (deep tissue injuries). Review of a progress note dated 7/27/26, at 7:49 a.m. indicated Resident R4 had a Stage 2 pressure injury on his left heel and a DTI on his right heel. Review of physician's order dated 7/28/26, indicated Resident R4 is to Offload b/l (bilateral) heels on heels up (Heelz Up device, a specialized cushion placed under the lower legs which allows the heels to be elevated off the bed to prevent pressure injury development) pillow while in bed. Review of Resident R4's Kardex, as of 7/30/26, failed to include instruction for staff to assist Resident R4 with the use of a Heelz Up pillow or regular pillow. During an observation on 7/31/26, at 11:58 a.m. Resident R4 was observed to have his left heel wound open to air with no sock on, and his right foot to have a sock on. Resident R4's heels were directly on the mattress without a Heelz Up pillow or other pillow in use. No additional pillow was observed in the room for use to elevate Resident R4's heels. When during the above request for staff to reposition Resident R2, after doing so, the staff walked past the bed of Resident R4 and did not assist him to relieve pressure on his foot. During a second observation on 7/31/26, at approximately 1:40 p.m., Resident R4 was observed to not have his heels elevated. During staff interviews completed on 7/31/26, nurse aides (NAs) confirmed that information related to elevating a resident's heels or the use of bunny boots is not viewable on their point of care system.NA Employee E2: If I see them in their room, I make sure I put them on them.NA Employee E3: Nurses are supposed to relay the message.NA Employee E4: We tell the agency aides if we know the resident needs them.NA Employee E5: We don't have any way of knowing unless the resident tells us. During an interview on 7/31/26, at approximately 3:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to make certain residents were provided necessary treatments and services, consistent with professional standards of practice, to treat and/or prevent pressure ulcers for four of seven residents. 28 Pa. Code: 211.10(d) Resident Care Policies28 Pa. Code: 211.12(d)(5) Nursing Services.		