STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395391	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asbury Health Center	700 Bower Hill Road Pittsburgh, PA 15243

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical records and staff interviews, it was determined that the facility failed to make certain medical records on each resident are complete and accurately documented for one of ten residents. (Resident R1). Finding include: A review of the facility policy Change in Condition dated 3/26/25, indicated to promptly notify the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. A review of the facility policy Charting and Documentation dated 3/26/25, indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. A review of the clinical record indicated Resident R1 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses that included Alzheimer's (progressive disease that destroys memory and other important mental functions), diabetes (too high or too low blood sugar), dysphagia (difficulty swallowing), heart failure (chronic condition in which the heart doesn't pump blood as well as it should). A review of the Minimum Data Set (MDS-periodic assessment of resident care needs) dated 5/5/25, indicated the diagnoses remained current. On 5/11/25, the resident became hyperglycemic (high blood sugar) with no order for insulin, the physician had to be notified and orders placed. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the clinical record revealed that on admission the resident was receiving two types of insulin (Lantus-long acting insulin given at bedtime, Humalog-short acting-given four times a day) and it was noted that these insulins were stopped on 5/6/25 with no documentation pertaining to stoppage of these medications. A review of the progress note on 5/11/25, revealed the physician note stating about a previous incident with insulins being discontinued and needing to be restarted, the note read, Resident did have an order for sliding scale and Lantus insulin at bedtime on 4/28/25, but was discontinued on 4/30/25, without notation. There was no documentation as to why the orders were discontinued on 4/30/25 or if there was a change in condition that prompted this, the review of orders noted that the insulins were immediately reordered at that time with no issues to care. During an interview on 6/3/25, at 2:10 p.m. the Director of Nursing and Nursing Home Administrator confirmed the above findings, and the facility failed to document a change in condition and that the medical records on each resident are complete and accurately documented for Resident R1. 28 Pa. Code: 211.5 (f)(g)(h) Clinical Records