

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2026
NAME OF PROVIDER OR SUPPLIER Asbury Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical and facility record review, facility submitted documents, and staff interviews, it was determined that the facility failed to provide adequate supervision to prevent resident elopement that created an immediate jeopardy situation for one of fourteen residents that were identified as at risk for elopement and did not reside on a secured unit (Resident R84). Findings Include: Review of the facility policy, Wandering and Elopements dated 3/1/26, indicated the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Review of the clinical record revealed Resident R84 was admitted to the facility on [DATE]. Review of the Minimum Data Sets (MDS - periodic assessment of resident care needs) dated 2/19/26 and 5/20/26, included diagnoses of hemiplegia (paralysis on one side of the body), 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 C: Cognitive Patterns indicated that Resident R84 has cognitive impairment. Review of an Elopement Evaluation assessments completed revealed: 2/18/26 - Not at risk of elopement. 4/12/26 - Assessment was incomplete. 5/19/26 - Not at risk of elopement. 7/18/26 - At risk of elopement. 7/20/26 - At risk of elopement. 7/30/26 - At risk of elopement. Review of the plan of care dated 4/13/26, indicated Resident R84 is an elopement risk/wanderer leaving the unit unattended related to impaired safety awareness. Further review of the care plan included one incomplete intervention in place for the risk for elopement from 4/13/26, through 7/20/26, Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: (no preferences included in care plan). Review of Resident R84's behavior monitoring for April through July 2026 revealed: April: No wandering documented, no documentation completed for 4/12/26, evening shift. May: Exit-seeking behavior documented on 5/21/26, evening shift. June: Exit-seeking and wandering behaviors documented on 6/21/26, evening shift. July: Exit-seeking behavior documented on 7/14/26, agitation, exit-seeking, frustration, and threatening others documented on 7/20/26, evening shift. Review of Resident R84's progress notes failed to reveal documentation related to the above instances of exit-seeking and wandering behaviors on 5/21/26, 6/21/26, and 7/14/26. Review of a new physician's order created 4/12/26, at 3:46 p.m. indicated for Resident R84 to have a Wanderguard (security bracelet that alerts when an identified resident approaches a monitored door) placed. Review of Resident R84's progress notes failed to include any progress notes created on 4/12/26. Review of a progress note dated 4/13/26, at 2:37 p.m. indicated, Had a long discussion with residents' brother regarding her wander guard. Answered all of his questions and explained that our main goal is just to keep her safe. He was satisfied with our conversation and all (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	properly. Door alarm company contacted to inspect for proper functionality, as an added safety measure. Door monitoring by staff has been implemented, pending completion of inspection by door alarm company. Review of information submitted by the facility dated 7/20/26, indicated, On 7/17/26 at approximately 10pm resident [Resident R84] was found off the unit near the vending machine and kitchenette area. Staff did not see her in her room when they went to give her medication and were unsure of where she was. Elopement protocol was initiated and resident was located approximately 5 minutes after identified as missing directly off the unit in the common area adjacent to her unit. Resident had wander guard in place and was stable with no incident or injury. Resident's most recent BIMS was 5/14/2026 and she scored an 11. Family and MD (Doctor of Medicine) notified of incident. Review of facility investigation documents dated 7/20/26, indicated, Resident found off unit in common area adjacent to unit. Stated she was let off by unknown visitor and wanted to go look outside unit. Stated no desire or intent to leave. Review of an employee statement dated 7/17/26, written by NA Employee E25 indicated, Around 9:30 p.m. I saw [Resident R84] in the front hall near my section. I redirected her toward her room. The door to exit Redwood had been alarmin for some time. I called security to ask them to shut off alarm and he said, 'Somebody already called, I'm by myself, I'll get up there.' Around 10:13, [RN Employee E4] asked if I'd seen [Resident R84], I told her I hadn't seen her for awhile. [RN Employee E4] called security to report her missing and I started looking on the 2nd floor. When I returned to the 3rd floor by administration, [RN Employee E28] said they found her. Review of an employee statement dated 7/17/26, written by NA Employee E26 indicated Resident R84 was found by the apartments off of Redwood (nursing unit). Review of an employee statement dated 7/17/26, written by NA Employee E27 indicated Resident R84 last seen in her room around 9:00 p.m. and was located in the assisted living area. Review of an employee statement dated 7/17/26, written by RN Employee E4 indicated, The resident was last seen at approximately 9:45 p.m. in the hallway outside the dining room while this nurse entered [room number] to perform wound care. About 10 minutes later, upon exiting the room, this nurse noticed the Fishbowl exit door alarming. The assigned nurse, CNAs, supervisor, immediately searched for the resident. This nurse notified security of the missing resident. Approximately 10:45 p.m., the assigned nurse located the resident in the independent living building and safely returned the resident to the unit. On 8/4/26, at 2:40 p.m. the Nursing Home Administrator (NHA) and the Director of Nursing (DON) were made aware that an Immediate Jeopardy situation existed and a corrective action plan was requested. The Immediate Jeopardy template was provided to the facility administration on 8/4/26, at 2:52 p.m. Review of clinical records revealed that the facility was out of compliance with resident safety and supervision since 4/12/26. On 8/4/26, at 7:05 p.m. an acceptable Corrective Action Plan was reviewed which included the following interventions: All residents were assessed in the facility for elopement risk on 7/20/26, no new residents were identified. Intervention for other residents identified as elopement risks included Wanderguard and door checks on all doors on 7/20/26, to address like resident safety. All units passed inspection except one door on redwood on 7/20/26. A door monitor was put into place on 7/20/26, for affected residents until room moves could be completed. [Resident R84] was moved to secured unit on 7/21/26. [Resident R91] was moved to new room on 7/22/26. Education regarding elopements was provided to all departments on 7/20/26, and completed on appropriate actions to take when the alarm system is activated and when a resident is noted to be missing. On 8/4/26, additional education initiated immediately related to IJ compliance for resident rights, comprehensive care plan, understanding elopement protocol and Wanderguard system and will be completed by 9am on 8/5/26. Root cause analysis conducted on 7/20/26 to determine R1 got off the unit by a visitor. Facility reviewed the policy Wandering and Elopements for (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	elopement prevention and post-elopement procedures on 8/4/26. DON or designee will audit to ensure all new admission, readmissions, quarterly assessments, and assessments with changes in condition will be reviewed that no change in elopement status occurred weekly x four, monthly x two beginning on 8/4/26. Care plan review audit will be conducted on 8/4/26, for like residents identified as elopement risk, to ensure appropriate monitoring and support are in place All POC (plan of correction) audit results and incidents will be reviewed at QAPI (Quality Assurance and Performance Improvement) monthly. Following a review of the Corrective Action Plan implementation on 8/5/26, the following was noted to have not been completed: Review of clinical records revealed the following residents, that were not reassessed for elopement on 7/20/26, were later identified as an elopement risk when reassessed on 8/5/26. Resident R26 identified as an elopement risk on 8/5/26. Resident R55 identified as an elopement risk on 8/5/26. Resident R73 identified as an elopement risk on 8/5/26. Review of clinical records revealed the following residents, that did not reside on a secure unit, to have been identified by the facility through elopement evaluations to be at risk to elope, without care plans developed to address wandering or elopement. Resident R46 identified on 7/20/26, and again on 8/5/26, as an elopement risk. Care plan was not initiated at the time of the survey. Resident R56 identified on 6/8/26, and again on 7/20/26, as an elopement risk. Care plan for wandering and elopement was not initiated until 8/4/26. Resident R95 identified on 3/18/26, 6/18/26, and again on 8/5/26, as an elopement risk. Care plan for wandering and elopement was not initiated until 8/4/26. Resident R114 identified on 2/14/26, 4/14/26, 7/14/26, and again on 8/5/26, as an elopement risk. Care plan for wandering and elopement was not initiated until 8/4/26. Resident R139 identified on 3/5/26, and again on 7/20/26, as an elopement risk. Care plan for wandering and elopement was not initiated until 8/4/26. Additionally, review of clinical records revealed the following residents, that did reside on a secure unit, to have been identified by the facility through elopement evaluations to be at risk to elope, without care plans developed to address wandering or elopement. Resident R42, identified on 6/16/26, and again on 8/5/26 as an elopement risk. Care plan was not initiated until 8/4/26. Resident R53, identified on 3/3/26, 6/3/26, and again on 8/5/26 as an elopement risk. Care plan was not initiated until 8/4/26. Resident R129, identified on 3/3/26, 6/3/26, and again on 8/5/26 as an elopement risk. Care plan was not initiated until 8/4/26. Review of resident clinical records on 8/5/26, revealed that only residents residing on the Redwood unit were reassessed for elopement, rather than All residents stated in the plan of correction above. Further review of Corrective Action Plan on 8/5/26, reviews of clinical records revealed all residents were reassessed for elopement on 8/5/26. Review of facility-provided sign-in sheets, dated 8/4/26, and 8/5/26, confirmed reeducation was provided to all facility staff on elopement risk identification, prevention, and actions to take in the event of an elopement. During interviews conducted on 8/5/26, 46 of 46 facility staff facility staff confirmed they received reeducation on: Whether they received reeducation. How to identify residents as risk for elopement (staff who were responsible for identifying elopement risk). What steps to take immediately and thereafter if a resident is missing. What actions to take if the resident refuses to return to the facility/unit. Whether they understand how the Wanderguard system functions. Further review of clinical records on 8/5/26, now revealed that care plan audits were completed, and new care plans were initiated for residents identified as at risk for elopement. On 8/5/26, review of review of facility documents confirmed a root cause analysis was completed. The Immediate Jeopardy was lifted on 8/5/26, at 3:28 p.m. when the action plan implementation was verified. During an interview on 6/30/26, at approximately 3:45 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide adequate supervision to prevent resident elopement that created an immediate jeopardy (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	situation for one of fourteen residents that were identified as at risk for elopement and did not reside on a secured unit. 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.		

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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 cross contamination and food borne illness. Findings include: During an initial observation of the kitchen from 10:15 a.m., through 10:52 a.m., the following was observed: -leaking water under kettle pan heaters-one of two Ice machine had a drainpipe sitting on floor with a black substance around pipe. The pipe is not over drain, and water is leaking onto floor.-Ice cream cooler has ice build up-wall cooler units had area leaking of first unit and fourth unit has broken hinge not allowing unit to close without force and the thermometer inside of cooler indicated 50-degree temperature and inside unit felt warm. During an interview on 8/4/26, at approximately 10:52 a.m., Certified Dietary Manager Employee E 23 confirmed that the facility failed maintain sanitary conditions in the Main Kitchen, which created the potential for cross contamination and food borne illness. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1) Management.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Resident Assessment Instrument User's Manual and clinical records, and resident and staff interviews, it was determined that the facility failed to make certain that comprehensive Minimum Data Set assessments were accurate and fully completed for seven of twelve residents (Resident R19, R21, R22, R51, R58, R93, and R118). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set Assessments (MDS - periodic assessment of care needs) dated October 2025, indicated that: Section B: Hearing, Speech, and Vision, defined Makes Self Understood as Able to express or communicate requests, needs, opinions, and to conduct social conversation in their primary language, whether in speech, writing, sign language, gestures, or a combination of these. Deficits in the ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and/or gesturing. Review of the coding instructions indicated Rarely or never understood should be coded when if, at best, the resident's understanding is limited to staff interpretation of highly individual, resident-specific sounds or body language. Section C: Cognitive Patterns, Question C0100 Should Brief Interview for Mental Status Be Conducted? (BIMS) should be coded as 0 if the resident is rarely/never understood, or it should be coded 1, and the BIMS assessment should be completed if the resident is at least sometimes understood. Section D: Mood, Question D0100 Should Resident Mood Interview Be Conducted? should be coded as 0 if the resident is rarely/never understood, and or it should be coded 1, and the assessment should be completed if the resident is at least sometimes understood. Review of the clinical record indicated Resident R19 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of kidney disease, Alzheimer's disease, and malnutrition. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R19 is Rarely/never understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R19 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question C0100 indicated that Resident R19 is rarely understood, and the Resident Mood Interview assessment was not completed. During an interview on 8/6/26, at approximately 11:55 a.m. the surveyor held a conversation with Resident R19. Resident R19 had clear speech, was able to provide her name, stated her birthday was in [birth month], and answered questions if she enjoyed the meals provided. Review of the clinical record confirmed Resident R19's birth month was as Resident R19 had stated. Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes, osteoporosis, and dementia. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R21 is Rarely/never understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R21 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question C0100 indicated that Resident R21 is rarely understood, and the Resident Mood Interview assessment was not completed. During an interview on 8/6/26, at approximately 12:00 p.m. the surveyor held a conversation with Resident R21. Resident R21 was confused, but had clear speech and was able to be understood. Review of the clinical record indicated Resident R58 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of kidney disease, diabetes, and dementia. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R58 is Rarely/never understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R58 is (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question C0100 indicated that Resident R58 is rarely understood, and the Resident Mood Interview assessment was not completed. During an interview on 8/6/26, at approximately 12:04 p.m. the surveyor held a conversation with Resident R58. Resident R58 had clear speech, was able to provide her name, when asked if she liked the food said it was, real good, answered questions on if the staff treat her respectfully and assist her with care, and when asked her birthday, stated it was the [day] of [month]. Review of the clinical record confirmed Resident R58's was as Resident R58 had stated. Review of the clinical record indicated Resident R22 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of heart failure, diabetes, and dementia. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R22 is Rarely/never understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R22 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question C0100 indicated that Resident R22 is rarely understood, and the Resident Mood Interview assessment was not completed. During an interview on 8/6/26, at approximately 12:10 p.m. the surveyor held a conversation with Resident R22. When asked his name, Resident R22 provided the preferred name listed in his clinical record. Resident R22 had clear speech, when asked if he liked the food said it was, good, answered questions on if the staff treat him respectfully and assist him with care, and when asked his birthday, stated the month, day, and year in numerical form. Review of the clinical record confirmed Resident R22 correctly stated his birthdate. Review of the clinical record indicated Resident R93 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of osteoporosis, malnutrition, and dementia. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R93 is Rarely/never understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R93 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question C0100 indicated that Resident R93 is rarely understood, and the Resident Mood Interview assessment was not completed. During an interview on 8/6/26, at approximately 12:15 p.m. the surveyor held a conversation with Resident R93. Resident R93 had clear speech, was able to provide her full name, when asked if the food tasted good said, it really does, answered questions on if the staff treat her respectfully and stated, pretty much, and was able to answer questions regarding ADL care and assistance in and out of bed. Review of the clinical record indicated Resident R51 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of anxiety, depression, and dementia. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R51 is Rarely/never understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R51 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question C0100 indicated that Resident R51 is rarely understood, and the Resident Mood Interview assessment was not completed. Review of the clinical record indicated Resident R118 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of kidney disease, malnutrition, and Alzheimer's disease. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R118 is Rarely/never understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R118 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question C0100 indicated that Resident R118 is rarely understood, and the Resident Mood Interview assessment was not completed. During an observation on 8/6/26, at approximately 12:20 p.m. Residents R51 and R118 were seen seated with Activities Department Employee E18. Resident R51 and R118 were speaking to Activities Department Employee E18. The surveyor sat at the table with Resident R51 and R118 and engaged (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	them in conversation. Both residents had clear speech and were able to hold a simple conversation. Resident R51 answered questions about the food activity the day prior, and when asked if she knew her birthday stated, I wasn't awake, but my mother would know. Resident R118 answered questions appropriately, and when asked if she had any concerns about her care, shook her head negatively. During an interview on 8/6/26, at 12:36 p.m. the Registered Nurse Assessment Nurse Employee E19 confirmed that if a resident is at least somewhat understood the resident should not be coded as Rarely/never understood and the BIMS and PHQ-9 assessments should be attempted. During an interview on 8/6/26, at approximately 3:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to make certain that comprehensive Minimum Data Set assessments were accurate and fully completed for seven of twelve residents. 28 Pa. Code: 211.5(f) Clinical records.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on facility policy and clinical record review and staff interview, it was determined that the facility failed to complete a restorative nursing program for four of seven residents reviewed for ADLs (activities of daily living) concerns (Residents R23, R26, R91, and R99). Findings include: Review of the facility policy Restorative Nursing Services dated 3/1/26, indicated the residents will receive restorative nursing care as needed to help promote optimal safety and independence. During an interview on 8/6/26 at 10:30 a.m., the Director of Nursing (DON) revealed that restorative activities are documented on the daily Documentation Report (Nurse Aide Documentation of Activities of Daily Living - ADL's.) Clinical record review for Resident R23 revealed a diagnoses list that included cognitive impairment, lack of coordination, and a history of falls. Review of the current care plan revised on 3/15/26, for Resident R23 revealed the resident requires assistance with transferring. An intervention included dependent assistance with all ADLs and restorative exercises for upper and lower extremities. Review of the current Therapy/Nursing Recommendation form status indicated Resident R23 was discharged from therapy and required active range of motion (AROM) to bilateral upper and lower extremities. Review of the daily Documentation Report dated July and August 2026 did not include documentation that the restorative tasks were completed daily as required. Clinical record review for Resident R26 revealed a diagnoses list that included stroke and paralysis on the right side of the body. Review of the current care plan revised on 3/27/26, for Resident R26 revealed the resident requires assistance with ambulating. An intervention included assist of one person with all ADLs and restorative exercises to upper extremities to include range of motion and lifting weights. Review of the current Therapy/Nursing Recommendation form status indicated Resident R26 was discharged from therapy and required AROM to bilateral upper and lower extremities, weight strengthening, and assist with walking up to 90 feet. Review of the daily Documentation Report dated July and August 2026 did not include documentation that the restorative tasks were completed daily as required. Clinical record review for Resident R91 revealed a diagnoses list that included anoxic brain damage (loss of blood circulation to the brain), dementia, and difficulty with walking and mobility. Review of the current care plan revised on 4/30/26, for Resident R91 revealed the resident requires assistance with ambulating and transfers and to utilize therapy recommendations. An intervention included restorative program for strengthening, transfers, and walking. Review of the current Therapy/Nursing Recommendation form status indicated Resident R91 was discharged from therapy and required AROM to bilateral upper and lower extremities, weight strengthening, and sit to stand exercises. Review of the daily Documentation Report dated July and August 2026 did not include documentation that the restorative tasks were completed daily as required. Clinical record review for Resident R99 revealed a diagnoses list that included diabetes, high blood pressure, muscle weakness, and lack of coordination. Review of the current care plan revised on 3/15/26, for Resident R99 revealed the resident requires partial to moderate assistance with ambulating and transfers and to utilize therapy recommendations. Interventions included a restorative program for AROM, and walking. Review of the current Therapy/Nursing Recommendation form status indicated Resident R99 was discharged from therapy and required assistance with walking with a wheeled walker up to 100 feet. Review of the daily Documentation Report dated July and August 2026 did not include documentation that the restorative tasks were completed daily as required. During an interview on 8/6/26 at 10:30 a.m., The Director of Nursing confirmed the above findings and that the facility failed to complete a restorative nursing program for ADLs concerns for Residents R23, R26, R91, and R99.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, resident observations, and staff interviews, it was determined that the facility failed to make certain that necessary care and services were provided for four of six residents (Resident R3, R62, R124, and R128). Findings include: Review of the facility policy, Activities of Daily Living, Supporting dated 3/1/26, indicated, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Review of the facility policy Call System, Resident, dated 3/1/26, with a previous review date of 3/25/25, indicated that calls for assistance are answered as soon as possible, but no later than 5 minutes. During an observation on 8/4/26, from 10:56 a.m. through 11:19 a.m., the call light was illuminating above resident R3's room, when MDS Coordinator Employee E21 answered the light Resident R3 indicated that she needed changed. MDS Coordinator confirmed that the call bell had been illuminating for 23 minutes. That is a long time to wait to be changed. During an observation on 8/4/26, from 10:56 a.m., through 11:15 a.m., the call light above Resident R124's room was illuminated, at 11:15 a.m., when the Nurse Aide entered the room, she closed the door behind her and proceeded to assist the resident. 18 minutes after the light was illuminated. During an interview on 8/4/26, at approximately 12:15 p.m., with the Nursing Home Administrator and Director of Nursing, they were made aware of the call light response times and confirmed they will review the call bell response with the staff. Review of the clinical record indicated Resident R62 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 7/7/26, included diagnoses of diabetes, atrial fibrillation, and the need for assistance with personal care. Review of Section GG: Functional Abilities indicated Resident R62 was needed substantial/maximal assistance to roll left and right in bed. Review of a progress note dated 7/28/26, at 2:12 p.m. indicated Resident R62 had moisture associated skin damage located at the base of her spine. Review of a physician's order dated 7/22/26, indicated Resident R62 required a wedge in bed at all times. During an observation on 8/5/26, at approximately 10:00 a.m. Resident R62 was noted to be lying in bed, on her back, without a wedge present. During an observation on 8/5/26, at approximately 2:27. Resident R62 was noted to be lying in bed on her back, with the wedge placed under the fitted sheet, at the same level as Resident R62's head. During an interview on 8/5/26, at approximately 3:00 p.m. Wound Nurse Employee E29 confirmed Resident R62's wedge should be placed at the level of her torso to assist in positioning Resident R62 on her side to alleviate pressure on her back. During an observation on 8/6/26, at approximately 11:31 a.m. Resident R62 was noted to be lying in bed on her back, with the wedge placed under the fitted sheet, at the same level as Resident R62's head. Review of the clinical record indicated Resident R128 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes, chronic kidney disease, and dementia. Review of Section C: Cognitive Patterns revealed Resident R128 had a moderate cognitive deficit. Review of Section GG: Functional Abilities indicated Resident R128 was dependent on staff for toileting hygiene. Review of Section H: Bladder and Bowel indicated Resident R128 was always incontinent of urine and frequently incontinent of stool. Review of Resident R128's plan of care for ADL Self Care Deficit indicated for staff to assist with toilet transfers and pericare (cleaning of the genitals and the anal area). During an observation on 8/4/26, at 9:50 a.m. Resident R128 was in bed. Upon entering Resident R128's room, a strong smell of urine was noted. Visible on the linen were two large discolored circles beneath Resident R128. After noting this, the surveyor exited the room to find staff to assist Resident R128. During an observation on 8/4/26, at (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9:55 a.m. the surveyor and Licensed Practical Nurse (LPN) Employee E17 noted the bed linen was saturated. The surveyor, with a gloved hand, pressed a disposable facial tissue to the larger, outer circle on the bed linen, and it was dry. Then pressed the facial tissue to the smaller inner circle, and the facial tissue became wet. Additionally, the blanket covering Resident R128 was observed to also be wet.LPN Employee E17 confirmed the above observations and stated that at times Resident R128 refuses care. Review of Resident R128's progress notes on 8/4/26, failed to reveal documentation of a care refusal. Review of Resident R128's point of care record for 8/4/26, indicated Resident R128 was incontinent of urine and stool at 12:56 a.m. No additional bowel and/or bladder care was documented for Resident R128 until 8/4/26, at 10:18 p.m. The point of care record provided the option for documenting refusals of care. No refusals of care were documented for Resident R128 on 8/4/26. During an interview on 8/6//26, at approximately 3:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to make certain that necessary care and services were provided for four of six residents. 28 Pa. Code: 210.10(d) Resident Care Policies. 28 Pa. Code: 211.12(d)(1) Nursing service.		

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, employment records and staff interviews, it was determined that the facility failed to maintain documentation that facility nursing personnel have current education and certification to provide basic life support, including CPR (cardiopulmonary resuscitation), to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives for 14 of 41 licensed nurses (Registered Nurse (RN) Employees E3, E4, E5, E6, and E7 and Licensed Practical Nurse (LPN) Employees E8, E9, E10, E11, E12, E13, E14, E15, and E16). Findings Include: Review of the facility, CPR (cardiopulmonary resuscitation) Policy dated [DATE], indicated To ensure timely and appropriate initiations of CPR by licensed nursing staff in accordance with facility policy, resident rights, and federal and state regulations. On [DATE], at approximately 11:00 a.m. the facility provided a list of 41 currently employed licensed nurses. On [DATE], the facility provided copies of the facility's licensed nurse's CPR certification cards. CPR certification cards were not available for review for RN Employees E3, E4, E5, E6, and E7 and LPN Employees E8, E9, E10, E11, E12, E13, E14, E15, and E16. During an interview on [DATE], at approximately 3:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to ensure that facility nursing personnel maintain current CPR certification for Healthcare Providers through a CPR provider whose training includes a hands-on session either in a physical or virtual instructor-led setting in accordance with accepted national standards for 14 of 41 licensed nurses. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **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 properly monitor weight and nutrition status by failing to obtain a monthly weight for one of six residents (Resident R6) and failed to identify and reassess residents for need for nutritional interventions for weight loss and/or skin issues for two of six residents. (Resident R97 and R9). Findings include: Review of the facility policy, Weight Assessment and Intervention dated 3/1/26, indicated, Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietician in writing. Review of the clinical record indicated Resident R97 was re-admitted to the facility on [DATE]. Review of Resident R97's Minimum Data Set (MDS, periodic assessment of resident care needs) dated 5/19/26, included diagnoses of Progressive Supranuclear Palsy (brain disease which affects movement, balance, vision and swallowing), history of a stroke, cognitive deficit. and malnutrition (lack of sufficient nutrients in the body). Review of Resident R97's current plan of care for potential nutritional problem, revised on 5/19/26, indicated for the facility Resident will maintain adequate nutritional status as evidenced by no unplanned significant weight changes and safely consume/tolerate food/fluids to meet 75% of estimated nutritional needs to support healthy skin integrity and to Monitor weights as ordered. Review of Resident R97's current plan of care risk for pressure ulcer development, revised on 1/30/26, indicated for the facility to monitor Resident R97's nutritional status. Review of Resident R97's nutritional assessment indicated the most recent assessment was completed on 5/15/26, and indicated to monitor as needed. Review of a physician's order dated 6/1/25, indicated to monitor weights for prevention. Review of Resident R97's weight record indicated that on 7/5/26, Resident R97 weight 124.0 pounds, and on 8/1/26, weighed 116.5 pounds, a loss of 7.5 pounds (6.05%) in one month. Review of a nutritional assessment dated [DATE], the last time Resident R97 was assessed by a Dietician, identified Resident R97 at risk for weight loss and actual weight loss with no interventions identified as being recommended or ordered. Review of the clinical record identified Resident R97 developed a 1cm x 1cm open area of her coccyx on 7/1/26, requiring treatment. The wound worsened per a progress note dated 7/28/26, during this time the dietician did not assess Resident R97 for potential additional nutritional interventions to assist with wound healing. During an interview on 8/6/26, at approximately 2:26 p.m., Dietician Employee E22 confirmed Resident R97 had not been reassessed after the development of a pressure ulcer on 7/1/26, and did not have nutritional interventions in place Review of the clinical record indicated Resident R6 was re-admitted to the facility on [DATE]. Review of Resident R6's MDS dated [DATE], included diagnoses of epilepsy (a long-term brain disorder that causes repeated and unprovoked seizures) and atrial fibrillation (an irregular and often very rapid heart rhythm). Review of Resident R6's current plan of care, initiated 6/20/26, indicated for the facility to, Monitor wts (weights) trends as ordered. Review of the nutritional assessment dated [DATE], indicated that, Upon re-admission a suggested wt loss- request reweigh. Review of a physician's order dated 6/29/26, indicated, Weekly weights every day shift for one day. Review of Resident R6's weight record from 6/28/26 through 8/4/26, failed to include a weight evaluation. Review of the clinical record indicated Resident R9 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), anemia (too little iron in the body causing fatigue), and malnutrition. Review of Resident R97's current plan of care for potential nutritional problem, revised on 6/25/26, indicated for the facility Resident will (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	maintain adequate nutritional status as evidenced by no unplanned significant weight changes and safely consume/tolerate food/fluids to meet 75% of estimated nutritional needs to support healthy skin integrity and to Monitor weights as obtained. Review of a physician's order dated 5/14/26, indicated Resident R9 received Glucerna (carbohydrate controlled nutritional supplement) for weight stabilization. Review of Resident R9's weight record indicated that on 5/3/26/26, Resident R9 weight 142.5 pounds, on 7/1/26, weighed 136.3 pounds, and on 8/3/26, weighed 125.00 pounds, a loss of 11.3 pounds (8.29%) in one month, and 17.5 pounds (12.28%) in three months. During an interview on 8/6/26, at approximately 2:26 p.m., Dietician Employee E22 confirmed Resident R9 did not have a reassessment or new interventions put in place to address her weight loss. During an interview on 8/6/26, at approximately 3:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to properly monitor weight and nutrition status by failing to obtain a monthly weight for one of six residents and failed to identify and reassess residents for need for nutritional interventions for weight loss and/or skin issues for two of six residents. 28 Pa. Code 201.18(b)(1)(Management.28 Pa. Code 211.10(c) Resident care policies.28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and observation, it was determined that the facility failed to provide care and services to maintain a resident's dignity for one of 11 sampled residents. (Resident R23) Findings include: Clinical record review revealed that Resident R23 had diagnoses that included dementia, anxiety, and osteoarthritis. The Minimum Data Set assessment (MDS) dated [DATE], indicated that the resident had mild cognitive impairment, and required assistance with dressing. Review of the current care plan revealed that Resident R23 had a self-care performance deficit related to dementia and that staff were to assist the resident with dressing. Observation on 8/4/2026, at 10:15 a.m., revealed Resident R23 was sitting on the bed naked in full view of anyone walking by in the hallway. The resident was being assisted with dressing by Certified Nurse Assistant (CNA) employee E1. During an interview on 8/4/26., at 10:25 a.m., CNA Employee E1 stated I forgot to pull the curtain after I brought the resident back from the bathroom. During an interview on 8/4/26, at 10:25 a.m., Executive Director Employee E2 confirmed the above findings and that the facility failed to provide care and services to maintain a resident's dignity for Resident R23. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on the review of facility policy and facility documents, observations and resident and staff interviews, it was determined that the facility failed to make certain grievance forms can be filed anonymously in one of four locations where grievance information is available. (Willow Unit). Findings include: A review of the facility policy Grievances last reviewed 3/1/26, indicated Grievances and/or complaints may be submitted orally or in writing, and may be filed anonymously. During an observation on 8/4/26 at 8:04 a.m., revealed the grievance policy/procedure was not posted at location on [NAME] Unit. Grievance forms available at grievance box location did not contain wording that a grievance form can be filed anonymously. During an interview on 8/6/26, at 3:30 p.m. the Nursing Home Administrator confirmed that the facility grievance policy and procedure failed to provide information on the residents' right to file a grievance anonymously. 28 Pa. Code 201.29(a)Resident rights		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job descriptions, clinical records, and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed effectively manage the facility to protect residents from elopement. This failure resulted in a resident, who was a known elopement risk, exiting the resident's assigned nursing unit unsupervised (Resident R1). This failure created an Immediate Jeopardy situation for one of fourteen residents who were documented as elopement risks (Resident R1). Findings include: Review of the facility-provided Nursing Home Administrator (NHA) job description indicated, The duties and responsibilities of the Administrator include performing a variety of tasks associated with creating a fulfilling resident experience, including resident care coordination, teammate oversight, and regulatory reporting and compliance for the Skilled Nursing area of the Community. Included in the list of responsibilities were: Supervise all department heads to ensure the community is operating according to standards and in compliance with regulatory guidelines. Investigate complaints, document findings, and review with ED; reports to regulatory agencies, where applicable. Organize information/data to identify/explain major trends, problems and causes. Compare and combine information to identify underlying issues. Generate actions to achieve long-range goals. Ensure documentation of care and services provided is accurate and timely. Review of the facility-provided Director of Nursing (DON) job description indicated, The Director of Nursing will plan, organize, develop, and direct the overall operation of the Nursing Services department. Included in the list of responsibilities were: Facilitates the coordination of nursing services and other departments to maintain quality care for residents. Recognizes and responds to changes in residents' conditions and documents observations, interventions, and outcomes. Oversees staffing to ensure appropriate resident care and ensure the applicable state licensure and certification standards are met. Reviews, monitors, intervenes, thoroughly investigates and reports incidents, complaints, and grievances made by residents, families, visiting individuals, agencies, teammates, and other departments. Based on findings identified in this report, the facility failed to prevent and protect residents from exiting the resident's assigned nursing unit unsupervised. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 8/6/26, at approximately 3:30 p.m. the NHA and current DON confirmed that facility administration failed effectively manage the facility to protect residents from elopement. This failure resulted in a resident, who was a known elopement risk, exiting the resident's assigned nursing unit unsupervised. This failure created an Immediate Jeopardy situation for one of fourteen residents who were documented as elopement risks. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2026
NAME OF PROVIDER OR SUPPLIER Asbury Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Bower Hill Road Pittsburgh, PA 15243	
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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, clinical records, and staff interview, it was determined that the facility failed to make certain that medical records on each resident are complete and accurately documented for one of eight residents (Resident R84). Findings include: Review of the facility, Charting and Documentation dated 3/1/26, indicated documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Review of the clinical record revealed Resident R84 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of hemiplegia (paralysis on one side of the body), 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 Resident R84's behavior monitoring for April through July 2026 revealed: April: No wandering documented, no documentation completed for 4/12/26, evening shift. May: Exit-seeking behavior documented on 5/21/26, evening shift. June: Exit-seeking and wandering behaviors documented on 6/21/26, evening shift. July: Exit-seeking behavior documented on 7/14/26, agitation, exit-seeking, frustration, and threatening others documented on 7/20/26, evening shift. Review of a new physician's order created 4/12/26, at 3:46 p.m. indicated for Resident R84 to have a Wanderguard (security bracelet that alerts when an identified resident approaches a monitored door) placed. Review of Resident R84's progress notes failed to any progress notes created on 4/12/26. Review of a progress note dated 4/13/26, at 2:37 p.m. indicated, Had a long discussion with residents' brother regarding her wander guard. Answered all of his questions and explained that our main goal is just to keep her safe. He was satisfied with our conversation and all questions were answered. Review of a physician progress note dated 4/13/26, at 4:27 p.m. indicated, Attending Attestation Note. [Resident R84] was seen today for fu (follow-up), mandatory 60 days recap visit. I did oversee /supervise fellow and later interviewed and examined [Resident R84] personally. Dw RN (Discussed with registered nurse) staff who updated me on her current course. I discussed the case with the fellow and agree with findings in her note and agree with her assessment and plan that we discussed and developed together. Review of a physician progress note dated 4/13/26, at 4:41 p.m. indicated, Yesterday (4/12/26) she was found wandering around outside on the curb and now has a wander guard on. Review of a progress note dated 6/15/26, at 12:12 p.m. repeated the above statement that Resident R84 was found outside. During an interview on 8/4/26, at approximately 2:30 p.m. the Nursing Home Administrator stated that the progress note from 4/13/26, at 4:41 p.m. was written by a medical fellow, and was inaccurate, and Resident R84 was not found outside on the curb. Review of a progress note dated 8/4/26, at 4:15 p.m. indicated, IDT F/U (interdisciplinary team follow-up) from 4/12/26, 1641 (4:41 p.m.), physician progress note stating, yesterday found wandering around outside on the curb. Investigation into this statement was completed in April, which included obtaining statements from staff members. The staff member who reportedly stated the resident was outside near curb was able to clearly state the resident was near the Hickory unit doorway and not outside of the facility. Documentation in the physician progress note was entered mistakenly, based on word of mouth staffing statements, and was completed by a fellow; a learning practitioner, training to become a physician. Fellow interviewed and stated she believes a staff member mentioned this information to her, but she was unable to specifically recall who, as this occurred several months ago. Investigation concluded, identifying no elopement occurred. Reviewed incorrect documentation with provider. Provider verbalized he is going (continued on next page)		

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to immediately correct the documentation R/T (related to) issue and reported he will complete education with involved staff member. During an interview on 8/6/26, at approximately 3:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to make certain that medical records on each resident are complete and accurately documented for one of eight residents. 28 Pa. Code: 211.5(f)(g)(h) Clinical records.		

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure that the resident and/or their representative received written notice of the facility bed-hold policy at the time of transfer for four of eight residents reviewed for hospitalization (Resident R9, R58, R62, and R98). Findings Include: Review of federal regulation S483.15(d) Notice of Bed-Hold Policy, indicated, facilities must provide written information about these policies to residents prior to and upon transfer for such absences. This information must be provided to all facility residents, regardless of their payment source. These provisions require facilities to issue two notices related to bed-hold policies. The first notice could be given well in advance of any transfer, i.e., information provided in the admission packet. Reissuance of the first notice would be required if the bed-hold policy under the State plan or the facility's policy were to change. The second notice must be provided to the resident, and if applicable the resident's representative, at the time of transfer, or in cases of emergency transfer, within 24 hours. It is expected that facilities will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. The notice must provide information to the resident that explains the duration of bed-hold, if any, and the reserve bed payment policy. It should also address permitting the return of residents to the next available bed. Review of facility Bed Hold and Returns dated 3/1/26, indicated, All residents/representatives are provided written information regarding the facility bed-hold policies which address holding or reserving a resident's bed during periods of absence, hospitalization and/or therapeutic leave. Residents are provided written information about these policies at least twice: Well in advance of any transfer (e.g., in the admission packet) At the time of transfer. If the transfer was an emergency, within 24 hours. Review of the clinical record indicated Resident R9 was readmitted to the facility on [DATE]. Review of Resident R9's minimum data set (MDS, periodic assessment of resident care needs) dated 5/11/26, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), cirrhosis (chronic damage leading to scarring and failure) of the liver and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Section C: Cognitive Patterns indicated Resident R9 had severe cognitive impairment. Review of a progress note dated 5/23/26, at 2:00 p.m. indicated that Resident R9 was transferred to the hospital due to abdominal pain. Further review of Resident R9's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the Resident or Resident Representative upon transfer. Review of the clinical record indicated Resident R58 was readmitted to the facility on [DATE]. Review of Resident R58's MDS dated [DATE], included diagnoses of high blood pressure, chronic kidney disease (gradual loss of kidney function), and dementia. Review of Section C: Cognitive Patterns indicated Resident R9 had severe cognitive impairment. Review of a progress note dated 4/15/26, at 2:43 p.m. indicated that Resident R58 was transferred to the hospital due to coughing up blood. Further review of Resident R58's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the Resident or Resident Representative upon transfer. Review of the clinical record indicated Resident R62 was readmitted to the facility on [DATE]. Review of Resident R62's MDS dated [DATE], included diagnoses of atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat) atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), diabetes, and high blood pressure. Review of Section C: Cognitive Patterns (continued on next page)		

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	indicated Resident R9 had severe cognitive impairment. Review of a progress note dated 7/1/26, at 3:41 p.m. indicated that Resident R62 was transferred to the hospital due to increased altered mental status and elevated blood pressure. Further review of Resident R62's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the Resident or Resident Representative upon transfer. Review of the clinical record indicated Resident R98 was readmitted to the facility on [DATE]. Review of Resident R98's MDS dated [DATE], included diagnoses of anxiety, depression, and dementia. Review of Section C: Cognitive Patterns indicated Resident R9 had severe cognitive impairment. Review of a progress note dated 7/1/26, at 3:41 p.m. indicated that Resident R98 was transferred and admitted to the hospital due to a urinary tract infection and pneumonia. Further review of Resident R98's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the Resident or Resident Representative upon transfer. During an interview on 8/6/26, at approximately 10:30 a.m. the Nursing Home Administrator confirmed that residents with Medicaid as a payer source were not provided bed-hold information upon transfer to the hospital. During an interview on 6/8/26, at approximately 3:45 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to ensure that the resident and/or their representative received written notice of the facility bed-hold policy at the time of transfer for four of eight residents reviewed for hospitalization. 28 Pa. Code 201.14(a) Responsibility of licensee		