STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395423	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corner View Nursing and Rehabilitation Center	6655 Frankstown Avenue Pittsburgh, PA 15206

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, clinical record reviews and staff interview it was determined that the facility failed to initiate a thorough investigation for injury of unknown origin for one of three residents reviewed (Resident R6).Findings include:Resident R6 was admitted to the facility on [DATE].Resident R6 has diagnosis of bipolar disorder (mental health condition that causes extreme mood swings, these include emotional highs and lows also known as depression) , enteropathy (disease of the small intestine), and hypertension (the force of blood pushing against your artery wall is consistently too high).Review of facility submitted documentation dated 10/9/25, indicated:On October 8, 2025, a small bulge was observed on R6 left shoulder by her son, leading to a medical evaluation by a facility provider. A subsequent X-ray on October 9, 2025, confirmed that her left shoulder was dislocated. During the evaluation, the cognitively intact R6's (BIMS 13.0 - brief interview mental status) indicated the injury occurred during a fall she had in August. She reported that she had not experienced any pain since the fall and stated that no one had harmed her. The medical provider, after receiving the X-ray results, verbally ordered a transfer to the emergency room at Shadyside Hospital. Following her hospital visit, a physician from Shadyside reported that the dislocation was already healing and could not be corrected by being put back in place. An orthopedic specialist was consulted for further assessment and a treatment plan. R6's son was informed of the findings and agreed with the planned course of care. During an interview on 10/16/25, at 12:00 p.m. Resident R6 Family indicated that they found an area on their mother's shoulder that was not there the previous day's They asked their mother if it hurt and she described it a s bullets going through her shoulder. Resident R6 Family member informed staff. Review of the clinical record physician orders indicated Resident R6 was to be transferred with the assistance of two people. Review of the clinical record showing facility task completed for residents indicated Resident R6 was transferred by one staff person. During an interview on 10/16/25, with NHA and DON - they confirmed that they were unaware of the concerns. During an interview on 10/16/25, at 3:30 p.m. the NHA and DON were informed that the facility failed to complete a thorough investigation for one of three residents (Resident R6). 28 Pa. Code 201.14 (a) Responsibility of Licensee.28 Pa. Code 201.18 (b)(1)(e) (1) 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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to obtain professional podiatry services for four of two residents reviewed for skin conditions (Resident R1, R2, R3, and R4).Findings include:Review of the facility's Resident Council Minutes dated 8/25/25, revealed Resident R1, R2, and R3 would like to see the podiatrist. Review of the admission record indicated Resident R1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/5/25, indicated diagnoses of multiple sclerosis (damages the protective cover around nerves called myelin in your central nervous system), mononeuropathy (damage that occurs to single nerve) of bilateral lower limbs, and unsteadiness on feet. Review of Resident R1's clinical record failed to include an order to consult podiatry. During an interview on 10/15/25, at 2:44 p.m. Resident R1 stated they need to see a podiatrist. Resident R1 was observed with socks on. Review of the admission record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/9/25, indicated diagnoses of anxiety, depression, and chronic pain syndrome. Review of Resident R2's physician order dated 5/2/25, indicated to consult podiatry and follow up as needed. During an interview on 10/14/25, at 2:37 p.m. Resident R2 indicated they have not seen podiatry and their toe nails have gotten longer. Resident R2 toe nails were observed to be thick and elongated. Documentation by the facility's contracted podiatry provider dated 8/19/25, failed to reveal Resident R2 was seen by podiatry as ordered.Review of the admission record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/18/25, indicated diagnoses of cognitive communication deficit, anxiety, and depression. Review of Resident R3's clinical record failed to include an order to consult podiatry. Review of the admission record indicated Resident R4 was admitted to the facility on [DATE], and readmitted [DATE]. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/3/25, indicated diagnoses of urinary tract infection, muscle weakness, and cognitive communication deficit. Review of Resident R4's physician order dated 8/11/25, indicated to consult podiatry and follow up as needed. Documentation by the facility's contracted podiatry provider dated 8/19/25, failed to reveal Resident R4 was seen by podiatry as ordered.During an interview on 10/14/25, at 11:51 a.m. Registered Nurse Unit Manager, Employee E1 stated all residents should have an as needed order to consult podiatry. If a resident needs to be seen by podiatry, the social worker is notified, then the residents are added to the list. Interview with the Director of Nursing (DON) on 10/14/25, at 2:53 p.m. confirmed Resident R1 and R3 failed to have an order to consult podiatry. During an interview on 10/14/25, at 3:41 p.m. the Nursing Home Administrator and DON confirmed the facility failed to obtain professional podiatry services for four of six residents reviewed (Resident R1, R2, R3, and R4).28 Pa. Code 211. 12(d)(1)(3)(5) Nursing services

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and interviews with staff, it was determined that the facility did not ensure that a physician s timely wrote, signed, and dated progress notes at each visit for one of four residents reviewed (Resident R4).Findings include:Review of the facility Physician Visits policy dated 4/2/25, revealed the attending physician must make visits in accordance with applicable state and federal regulations. The attending physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation. A physician visit is considered timely if it occurs not later than ten days after the visit was required. Review of the admission record indicated Resident R4 was admitted to the facility on [DATE], and readmitted [DATE]. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/3/25, indicated diagnoses of urinary tract infection, muscle weakness, and cognitive communication deficit. Review of late entry progress note effective 7/7/25, entered on 8/3/25, by Medical Director, Employee E2 revealed the resident was seen in follow up care after readmission. The progress note was entered, signed , and dated a total of 27 days later. Review of late entry progress note effective 7/14/25, entered on 8/14/25, by Medical Director, Employee E2 revealed the resident was seen in follow up care after readmission. The progress note was entered, signed ,and dated a total of 31 days later. Review of late entry progress note effective 8/13/25, entered on 9/14/25, by Medical Director, Employee E2 revealed the resident was seen in follow up care after readmission. The progress note was entered, signed ,and dated a total of 32 days later. Resident R4 was discharged from the facility on 8/28/25. During an interview on 10/14/25, at 3:41 p.m. the Nursing Home Administrator and DON confirmed the facility failed to ensure that a physician timely wrote, signed, and dated progress notes at each visit for one of four residents reviewed (Resident R4).28 Pa. Code: 211.12(d)(5) Nursing services.28 Pa. Code: 211.2(a) Physician services.28 Pa. Code: 211.5(f) Clinical records.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and clinical records, and staff and resident interviews, it was determined that the facility failed to ensure that a dental appointment was scheduled for two of four residents reviewed (Resident R2 and R5).Findings include:Review of the facility's Resident Council Minutes dated 8/25/25, revealed Resident R2 and R5 would like to see the dentist. Review of the admission record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/9/25, indicated diagnoses of anxiety, depression, and chronic pain syndrome. Review of Resident R2's physician order dated 5/2/25, indicated to consult dental as needed. During an interview on 10/14/25, at 2:37 p.m. Resident R2 stated they have not seen a dentist. Documentation by the facility's contracted dental provider dated 10/9/25, failed to reveal Resident R2 was seen by the dentist.Review of the admission record indicated Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/15/25, indicated diagnoses of high blood pressure, dementia (the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities), and constipation. Review of Resident R5's physician orders, failed to include a dental consult. During an interview on 10/14/25, at 2:40 p.m. Resident R5 stated I have not seen a dentist. Resident R5 was observed with upper dentures and indicated they have developed a sore on the bottom of their gums from chewing. Documentation by the facility's contracted dental provider dated 10/9/25, failed to reveal Resident R5 was seen by the dentist.During an interview on 10/14/25, at 11:51 a.m. Registered Nurse Unit Manager, Employee E1 stated all residents should have an as needed order to consult dental. If a resident needs to be seen by a dentist, the social worker is notified, then the residents are added to the list. Interview with the Director of Nursing (DON) on 10/14/25, at 2:53 p.m. confirmed Resident R5 failed to have an order to consult dental. During an interview on 10/14/25, at 3:41 p. m. the Nursing Home Administrator and DON confirmed the facility failed to obtain dental services for two of four residents reviewed (Resident R2 and R5).28 Pa. Code 211.12(d)(1)(3)(5) Nursing services28 Pa. Code 211.15(a) Dental Services.