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	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Champion City 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interview, it was determined that the facility failed to notify the physician of a change in condition for one of three residents (Resident R4). Findings include:Review of the clinical record revealed Resident R4 was admitted to the facility on [DATE].Review of Resident R4s MDS dated [DATE], indicated diagnoses of end stage renal disease, diabetes mellites and congestive heart failure (long-term condition in which your heart can't pump blood well enough to meet the body's needs). Review of Resident R4's progress note dated 5/12/26 indicated resident was in the ED (emergency department) on 5/11/26 for abdominal pain. There was no indication it was reported to the physician or an order to send to the hospital. During an interview on 5/19/26, at 2:00 p.m. Regional Nursing Home Administrator Employee E6 confirmed that the facility failed to notify the physician for change of condition as required. 28 Pa. Code: 211.12(d)(1) Nursing services.

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and documentation, staff and resident interviews it was determined that the facility failed to protect residents from neglect for one of five residents (Resident R1).Findings include: Review of facility policy Identifying Types of Abuse dated 10/29/25, indicated Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident requires but the facility fails to provide them, and this has resulted in (or may result in) physical harm, pain, mental anguish or emotional distress. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/18/26, indicated diagnoses of olecranon fracture (a break in the bony tip of the elbow), dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), and falls. Section C0500 indicated a Brief Interview for Mental Status (BIMS is a screening test that aids in detecting cognitive impairment) score of 00, severe impairment. Review of facility provided documents indicated on 5/8/2026, at 6:30 a.m., the 11:00 p.m. - 7:00 p.m. Registered Nurse (RN) Supervisor, Employee E1 reported to the Director of Nursing, that Nurse Aide (NA) Employee E2 placed a sheet around Resident R1's hips during the 11:00 p.m.- 7:00 p.m. shift. Resident R1 was seated in a chair in front of the television, and the sheet prevented resident from transitioning from sitting to standing. Upon investigation the sheet was found to only be in place less than 15 minutes. Resident R1 resides on the locked dementia unit. Review of RN Supervisor Employee E1's signed witness statement dated 5/7/26, indicated RN was making rounds at 5:15 a.m. on the Third Floor. Resident R1 was sitting quietly in the common area. RN went over to resident and saw that resident was tied to the chair with two sheets. One sheet was tied over the arms; the other sheet was tied across the waist. RN tried to untie resident, but the sheets were so tightly knotted to the chair arms that the RN couldn't. RN untied resident from the back. Skin exam found no injuries or any bruising. Resident R1's NA Employee E2 was on a break at the time. RN called NA Employee E2 from the supervisor phone and asked if they were the one who tied resident to the chair and NA Employee E2 replied Yeah, I did it.' Review of NA Employee E2's signed witness statement dated 5/7/26, at 11:00 a.m. that was conducted during a telephonic interview by Infection Preventionist (IP) Employee E3, and Regional Nurse Employee E4, indicated Resident R1 was peeing everywhere. NA Employee E2 indicated, I know it was wrong and not right. I put a sheet around resident's waist to make a seatbelt for resident in the wheelchair with a slipknot in the back. Resident was not there for hours, and I only had one sheet around resident. I think the RN supervisor was having a bad day and called me out. It's not like I tied resident up and put resident in a room and left resident for hours. I put resident in front of the television. I did the sheet at 5:00 a.m. and went on a break at 5:06 a.m. and I forgot I had put the sheet around resident. RN Supervisor Employee E1 called me at 5:11 a.m. and asked me why I left the resident like I did. I was trying to take my scheduled break, and I was by myself because the other NA was sent home. I was tired of chasing resident around. I was just trying to keep resident safe, and from going into the other residents' rooms and waking them up. Review of Licensed Practical Nurse (LPN) Employee E5's signed witness statement dated 5/7/26, indicated I was called into the common area television room by the night shift supervisor. Resident R1 was found restrained around the waist area while sitting in the chair. NA Employee E2 stated she applied the restraint for his safety while NA was making their last rounds. I saw the restraint only when I was called over for a closer look by the RN Supervisor at around five thirty or five forty-five in the morning. Interview on 5/19/26, at 2:00 p.m. the Regional Nurse Employee E4 confirmed the facility failed to protect residents from neglect for one of five residents (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Resident R1). 28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(b)(1)(3) Management.28 Pa. Code 201.29(a)(c) Resident Rights28 Pa. Code 211.10(c)(d) Resident Care Policies.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to ensure that residents were free from physical restraints for one of five residents (Resident R1). Findings include: Review of facility policy Use of Restraints dated 10/29/25, indicated:-Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience or for the prevention of falls.-Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body.-Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including placing a resident in a chair that prevents the resident from rising. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/18/26, indicated diagnoses of olecranon fracture (a break in the bony tip of the elbow), dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), and falls. Section C0500 indicated a Brief Interview for Mental Status (BIMS is a screening test that aids in detecting cognitive impairment) score of 00, severe impairment. Review of Resident R1's physician orders failed to include orders of restraint use of any type. Review of Resident R1's care plan failed to include documentation of restraint use of any type. Review of facility provided documents indicated on 5/8/2026, at 6:30 a.m., the 11:00 p.m. - 7:00 p.m. Registered Nurse (RN) Supervisor, Employee E1 reported to the Director of Nursing, that Nurse Aide (NA) Employee E2 placed a sheet around Resident R1's hips during the 11:00 p.m.- 7:00 p.m. shift. Resident R1 was seated in a chair in front of the television, and the sheet prevented resident from transitioning from sitting to standing. Upon investigation the sheet was found to only be in place less than 15 minutes. Resident R1 resides on the locked dementia unit. Review of RN Supervisor Employee E1's signed witness statement dated 5/7/26, indicated RN was making rounds at 5:15 a.m. on the Third Floor. Resident R1 was sitting quietly in the common area. RN went over to resident and saw that resident was tied to the chair with two sheets. One sheet was tied over the arms; the other sheet was tied across the waist. RN tried to untie resident, but the sheets were so tightly knotted to the chair arms that the RN couldn't. RN untied resident from the back. Skin exam found no injuries or any bruising. Resident R1's NA Employee E2 was on a break at the time. RN called NA Employee E2 from the supervisor phone and asked if they were the one who tied resident to the chair and NA Employee E2 replied Yeah, I did it.' Review of NA Employee E2's signed witness statement dated 5/7/26, at 11:00 a.m. that was conducted during a telephonic interview by Infection Preventionist (IP) Employee E3, and Regional Nurse Employee E4, indicated Resident R1 was peeing everywhere. NA Employee E2 indicated, I know it was wrong and not right. I put a sheet around resident's waist to make a seatbelt for resident in the wheelchair with a slipknot in the back. Resident was not there for hours, and I only had one sheet around resident. I think the RN supervisor was having a bad day and called me out. It's not like I tied resident up and put resident in a room and left resident for hours. I put resident in front of the television. I did the sheet at 5:00 a.m. and went on a break at 5:06 a.m. and I forgot I had put the sheet around resident. RN Supervisor Employee E1 called me at 5:11 a.m. and asked me why I left the resident like I did. I was trying to take my scheduled break, and I was by myself because the other NA was sent home. I was tired of chasing resident around. I was just trying to keep resident safe, and from going into the other residents' rooms and waking them up. Interview on 5/19/26, at 2:00 p.m. the Regional Nurse Employee E4 confirmed the facility failed to ensure that residents were free from physical restraints for one of five residents (Resident R1). 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	201.18(b)(1)(3) Management. 28 Pa. Code 201.29(a)(c) Resident Rights 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident records, facility documentation, incidents submitted to the local State field office, and staff interviews it was determined that the facility failed to submit a report of an allegation of resident-to-resident abuse to the local State field office for one of five sampled residents (Resident R2).Findings include: Review of facility policy Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated 10/329/25, indicated all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations), and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Immediately is defined as within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Review of the clinical 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 5/9/26, indicated diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and depression. Section C0500 indicated a Brief Interview for Mental Status (BIMS is a screening test that aids in detecting cognitive impairment) score of 10, moderate cognitive impairment. Review of Resident R2's progress notes dated 5/10/26, at 9:00 p.m. indicated Resident R2 was pushed to the floor by another resident causing Resident R1 to injure the back of the head, and that sent Resident R2 out to the hospital. Review of Resident R2's progress notes dated 5/10/26, at 10:57 p.m. further indicated an altercation between two residents occurred at approximately 9:00 p.m. Resident R2 charged at another resident in lounge area, who was sitting, watching television; this resident shoved Resident R2 away causing her to fall back and hit her head on floor. Moderate blood flow on the floor, one-inch open area; pressure held. Resident to chair once blood stopped. Dressing to head. Supervisor aware and on unit. Dr. Golani notified, patient being sent to outlying hospital. Review of facility provided report to the local State field office dated 5/10/26, at 9:00 p.m. indicated Event Type: Transfer/admission to Hospital Because of Injury/Accident. Resident R2 experienced a witnessed fall while ambulating on the unit, hitting head on the floor. Resident has a BIMS of 12 and is capable of taking off and putting on resident clothing and shoes. Resident had removed their shoes and was wearing socks. Sustained small laceration three centimeters (cm) to back of scalp. Resident sent to the Emergency Department for evaluation and treatment. Submitted by the Director of Nursing. Interview on 5/19/26, at 2:30 p.m. Regional Nurse Employee E4 indicated the Director of Nursing was on vacation. Further interview on 5/19/26, at 2:31 p.m. Regional Nurse Employee E4 indicated the facility provided report to the local State field office dated 5/10/26, at 9:00 p.m. was not reflective of the resident to resident abuse documented in the progress notes and that the facility failed to submit a report of an allegation of resident to resident abuse to the local State field office for one of five sampled residents (Resident R2). 28 Pa. Code: 201.14(a)(c) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(3)(e)(1) Management.28 Pa. Code: 201.20(b) Staff development.28 Pa. Code: 211.10(c)(d) Resident care policies.

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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 interviews, it was determined that the facility failed to initiate a thorough investigation for an allegation of resident-to-resident abuse for one of five residents (Resident R2) Findings include: Review of facility policy Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated 10/329/25, indicated all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations), and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Review of the clinical 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 5/9/26, indicated diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and depression. Section C0500 indicated a Brief Interview for Mental Status (BIMS is a screening test that aids in detecting cognitive impairment) score of 10, moderate cognitive impairment. Review of Resident R2's progress notes dated 5/10/26, at 9:00 p.m. indicated Resident R2 was pushed to the floor by another resident causing Resident R1 to injure the back of the head, and that sent Resident R2 out to the hospital. Review of Resident R2's progress notes dated 5/10/26, at 10:57 p.m. further indicated an altercation between two residents occurred at approximately 9:00 p.m. Resident R2 charged at another resident in lounge area, who was sitting, watching television; this resident shoved Resident R2 away causing her to fall back and hit her head on floor. Moderate blood flow on the floor, one-inch open area; pressure held. Resident to chair once blood stopped. Dressing to head. Supervisor aware and on unit. Dr. Golani notified, patient being sent to outlying hospital. Review of Resident R2's form #1812 Physical Aggression initiated, dated 5/10/26, at 9:00 p.m. indicated after the altercation between two residents, Resident R2 was pushed to the floor by other resident and hit the back of the head to cause it to open and start bleeding. Staff nurse stopped the bleeding after several attempts and wrapped the head in bandages. Physician, Director of Nursing, and family were notified as well as the police. Review of facility provided report to the local State field office dated 5/10/26, at 9:00 p.m. indicated Event Type: Transfer/admission to Hospital Because of Injury/Accident. Resident R2 experienced a witnessed fall while ambulating on the unit, hitting head on the floor. Resident has a BIMS of 12 and is capable of taking off and putting on resident clothing and shoes. Resident had removed their shoes and was wearing socks. Sustained small laceration three centimeters (cm) to back of scalp. Resident sent to the Emergency Department for evaluation and treatment. Submitted by the Director of Nursing. 28 Pa. Code: 201.14(a)(c) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(3)(e)(1) Management.28 Pa. Code: 201.20(b) Staff development.28 Pa. Code: 211.10(c)(d) Resident care policies.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 review of facility policy, clinical record review, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider and failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold for an agreed upon rate during a hospitalization) for one of three residents (Resident R4).Findings include: Review of facility policy Transfer or Discharge Documentation dated 10/29/25, indicated when a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility of provider. Review of the clinical record revealed Resident R4 was admitted to the facility on [DATE]. Review of Resident R4s MDS dated [DATE], indicated diagnoses of end stage renal disease, diabetes mellites and congestive heart failure (long-term condition in which your heart can't pump blood well enough to meet the body's needs). Review of the clinical record indicated Resident R4's was transferred to the hospital on 5/11/26. Review of Resident R4's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. During an interview on 5/19/26, at 2:00 p.m. Regional Nursing Home Administrator Employee E6 confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider, failed to notify the resident's representative of the facility bed-hold policy for Residents R4 as required. 28 Pa. Code: 201.14(a)Responsibility of licensee.28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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 review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to perform post-fall documentation of assessment and failed to make certain that residents were provided appropriate treatment and care in accordance with professional standards of practice for one of five residents (Residents R3). Findings include: Review of facility policy Assessing Falls and Their Causes dated 10/29/25, indicated if an assessment rules out significant injury, help the resident to a comfortable sitting, lying, or standing position, and then document relevant details. Review of the clinical 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 5/6/26, indicated diagnoses of high blood pressure, renal insufficiency (a condition in which the kidneys lose the ability to remove waste and balance fluids), and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Review of Section GG indicated supervision or touching assistance - helper provides verbal cues and/or touching/steadying and/or contact guard assistance as for Section K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space. Review of Resident R3's current care plan indicated at risk for falls due to history of falls, impaired mobility, and muscle weakness. Review of Resident R3's progress note dated 5/18/26, at 7:52 a.m. indicated writer was called by the receptionist on the first floor, which stated that Resident R3 was sitting on the floor in the lobby. Writer went to the first floor and resident was sitting on floor on buttocks. Resident stated that they were trying to pick something up off of the floor and put their right knee on the floor and could not get up so they sat on their buttocks on the floor. Resident fell at 7:40 p.m. on the right side of the receptionist desk. Resident was lifted up by Security and the Receptionist. Resident stated that they were not hurt. Resident refused vital signs. Interview on 5/19/26, at 2:26 p.m. Regional Nurse Employee E4 confirmed that a documented assessment is required prior to moving a resident who has fallen and that the facility could not produce a documented assessment prior to assisting Resident R3 from the floor. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of personnel files and staff interview it was determined that the facility failed to complete annual nurse aid employee evaluation for one of three records (Nurse aide (NA) Employee E2).Findings include: Review of employee personnel files on 5/20/26, at 2:30 p.m. indicated the following: Review of NA Employee E2's personnel record indicated a date of hire as 3/6/25. Further review of NA Employee E2's personnel record indicated a Job Description/Competency/Evaluation (Annual and Probationary) document dated 3/6/25. The form was entirely blank except NA Employee E2's signature on the last page dated 3/6/25. No documentation for the year 2026 was presented. Interview on 5/19/26, at 2:30 p.m. Regional Nursing Home Administrator Employee E6 confirmed the facility failed to complete annual nurse aid employee evaluation as required for NA Employee E6. 28 Pa. Code: 201.18(b)(1) Management.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on facility policy, menu, observations, and staff interviews, it was determined that the facility failed to follow the menu for five of five residents (Resident R6, R7, R8, R9, and R10).Findings include: Review of facility policy entitled Food and Nutrition Services dated 10/29/25, indicated each resident is provided with a nourishing, palatable, well-balanced diet that meets hir or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Food and nutrition services staff will inspect food trays to ensure that the correct menu is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature. Review of the admission record indicated Resident R7 was admitted to the facility 1/27/23. Review of Resident R7's physician orders indicated:Magic cup (oral nutritional supplement) with meals TID (three times per day) for weight support.Mighty shakes (oral nutritional supplement) with meals for weight support TID with meals. During an observation of Resident R7's lunch meal tray on 5/19/26 failed to include a magic cup or a mighty shake as ordered. During an interview on 5/19/26, at 11:50 a.m., Nurse Aide (NA) Employee E7 confirmed that neither oral nutritional supplement, magic cup or mighty shake, were present on Resident R7's lunch tray. A review of the provided menu indicated that the lunch meal on 5/19/26, was as follows:Cube steak, mushroom gravy, buttered noodles, seasoned zucchini, dinner roll, and peach crisp. During an observation of lunch trays on the sixth and fourth floor on 5/19/26, revealed the following:Resident R6 - was served diced peaches, not peach crisp as menu indicated.Resident R7 - was served diced peaches, not peach crisp as menu indicated.Resident R8 - was served diced peaches, not peach crisp as menu indicated. Resident R9 - was served diced peaches, not peach crisp as menu indicated. Resident R10 - was served diced peaches, not peach crisp as menu indicated. During an interview on 5/19/26, at 12:20 p.m., Executive Chef (EC) Employee E8 confirmed that the facility failed to serve peach crisp for lunch meal as menu indicated. During an interview on 5/19/26, at 1:01 p.m., Dietary Supervisor (DS) Employee E9 stated that Diet Aide (DA) Employee E10 failed to make peach crisp as part of her cold production responsibilities for lunch meal service. During an interview on 5/19/26, at 3:20 p.m., Regional Nursing Home Administrator Employee E6 confirmed that the facility failed to follow the menu for five of five residents (Resident R6, R7, R8, R9, and R10). 28 Pa. Code: 211.6(a) Dietary services

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	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Champion City 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 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 clinical records and staff interview, it was determined that the facility failed to appropriately document progress notes in the clinical record for one of three residents (Resident R5). Findings include:Review of the clinical record revealed Resident R5 was admitted to the facility on [DATE].Review of Resident R5's MDS dated [DATE], indicated diagnoses of Bipolar (mental health condition characterized by alternating episodes of mania and depression, affecting mood, energy and thought), depression and neurologic neglect syndrome (cognitive disorder). Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Resident R5's MDS assessment section C0200 BIMS score was a 11, indicating moderately impaired Review of Resident R5's medical record revealed two letters' regarding her Medicaid Long-Term Care Application. One dated 4/14/26 and 5/7/26, both were signed by Resident R5. During an interview on 5/19/26, at 1:00 p.m. Regional Nurse Employee E4 confirmed that the facility shouldn't have had Resident R5 sign the letters because of being cognitively impaired. 28 Pa. Code: 211.5(f)(g)(h) Clinical Records.