STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395561	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reformed Presbyterian Home	2344 Perrysville Avenue Pittsburgh, PA 15214

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 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, review of facility documentation, observations, and staff and resident interviews, it was determined that the facility failed to provide Activities of Daily Living (ADL) assistance for three of three residents reviewed (Resident CR1, R2, and R3).Findings include: Review of facility policy, Activities of Daily Living (ADLs), dated 7/15/25, revealed ADL tasks include toileting and feeding. It is the facility policy to provide a resident the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. The nurse aides must document all ADL support and performance using the electronic health record. Proper position is maintained for eating and an elimination schedule is maintained for regularity. Clinical record review revealed Resident CR1 was admitted to the facility on [DATE], with diagnoses of heart failure, stroke, and diabetes mellitus. Review of physician orders dated 10/24/26, indicated to consult hospice. Review of Resident CR1's hospice Initial Comprehensive assessment dated [DATE], revealed the resident needs complete care of all adls including feeding. Review of Resident CR1's progress note dated 11/14/25, revealed the resident requires assistance from staff with meals and all aspects of care. It was revealed the resident had worsening symptoms in hands since return from the hospital; difficulty with fine motor movements, feeding self. Review of Resident CR1's clinical record from 10/28/25, to 12/21/26, failed to include an order to assist the resident with feeding. Review of physician orders dated 12/22/26, indicated the resident requires assistances with meals. Review of Resident CR1's Documentation Survey Report V2 Dec-25 revealed on 12/23/25, 12/24/25, and 12/25/25, at 7:00 a.m. and 12:00 p.m. the resident was not provided help or staff oversight at anytime while eating. A further review failed to include any documentation of the percentage of fluid intake at meals and food eaten. Resident CR1's Documentation Survey Report V2 Dec-25 failed to include evidence the resident was assisted with toilet use for a total of 18 shifts in the month of December. Clinical record review revealed Resident R2 was admitted to the facility on [DATE], with diagnosis to include heart failure, high blood pressure, and malnutrition. During an interview on 3/18/26, at 9:23 a.m. Resident R2 stated sometimes there are issues getting changed and indicated she can wait a while to be assisted with toileting. Resident R2's Documentation Survey Report V2 Dec-25 failed to include evidence the resident was assisted with toilet use for a total of six shifts in the month of December. Clinical record review revealed Resident R3 was admitted to the facility on [DATE], with diagnosis to include dementia, malnutrition, adult failure to thrive, and dysphagia (difficulty swallowing). Review of Resident R3's physician order dated 8/12/25, indicated the resident was ordered a pureed texture, thin consistency diet. Directions included an upright posture, slow rate, small bites/sips, set-up and feed from staff as needed. Review of Resident R3's care plan on 3/18/26, indicated to assist to an upright position for all meals as tolerated, set up and assist with eating as needed, monitor/document/report as needed any signs and symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusal to eat, appears concerned during meals. During an interview on 3/18/26, at 9:30 a.m. RN Supervisor, Employee E1 provided this writer with an undated document titled Residents that need assistance with meals. Resident R3 was included. During an observation on 3/18/26, at 11:58 (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a.m. Nurse Aide, Employee E4 set up Resident R1's tray and exited the room. During an observation on 3/18/26 , at 11:59 a.m. Resident R3 was observed eating in bed, not in an upright position. The resident was observed eating rapidly. During an interview and observation of Resident R3 eating on 3/18/26, at 12:02 p.m. Registered Nurse, Employee E5 stated the resident was eating at her normal rate and confirmed the resident was not sitting in an upright position or being assisted with meals. During an interview on 3/18/26, at 12:32 p.m. NA, Employee E3, stated all staff must document at least each shift for feeding and toileting. NA, Employee E3 stated if not documented not done, it has to be done. Interview on 3/18/26, at 12:50 p.m. the Director of Nursing (DON), stated staff are expected to check on residents every one to two hours. The DON stated for toileting, the assistance level, size of bowel movement, and support provided must be documented. For eating it was indicated the percentage of amount eaten and amount of fluids as well as assistance provided is documented in the clinical record. The DON confirmed the facility failed to document ADL care was documented and provided for Resident CR1, R2, and R3. Interview on 3/18/26, at 1:30 p.m. the Nursing Home Administrator and Director of Nursing confirmed the facility to provide Activities of Daily Living (ADL) assistance for three of three residents reviewed (Resident CR1, R2, and R3). 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code: 211.12(d)(1)(5) Nursing services