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	05/05/2026

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 0600 Level of Harm - 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, facility provided documents and clinical records, and staff interviews, it was determined that the facility failed to protect residents from abuse and neglect which resulted in actual harm of a hematoma to right forehead, patella (kneecap) fracture, and ankle sprain for one of three residents (Resident R1). This deficiency is cited as past non-compliance. Findings include: Review of the facility policy Prevention of Abuse and Response dated 7/15/25, indicated abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish or emotional distress. Review of the admission record indicated that 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 2/5/26, indicated diagnoses of dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), high blood pressure, and depression. Section C0500 indicated a Brief Interview for Mental Status (BIMS- is a screening test that aids in detecting cognitive impairment) score of 12 - moderately impaired cognition. Section GG - Functional Abilities - Mobility, Question GG0170R indicated the resident was coded at a 03 partial/moderate assistance. Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort for wheeling self 50 feet in a wheelchair and making two turns. Review of Resident R1's care plan dated 4/19/26, indicated to provide assistance for ADL's (activities of daily living) as needed. Resident is at risk for falls and related injury due to weakness and history of falling. Goal indicated that resident will not fall, but if a fall occurs, resident will not sustain significant injury through next review. Review of Resident R1's clinical record nursing progress note dated 4/24/26, at 6:57 p.m., indicated writer was alerted by a Nurse Aide (NA) that Resident R1 had fallen from the wheelchair. When approached the resident was found lying on the head with the lower torso up by the wheelchair seat. The NA behind the chair stated they were trying to assist resident through the doors and the resident fell forward. Resident was assessed and noted to have a hematoma (collection of blood outside of the vessels causing swelling, pain and inflammation) to the right forehead. Measured 2.5 centimeters (cm) long by 6 cm wide. Site was bleeding. Resident also had an abrasion to the right knee that was bleeding 2cm long by 2cm wide. Resident complained of head pain. 911 was called and resident was transferred to the emergency room. Further review of Resident R1's clinical record nursing progress note dated 4/25/26, at 1:05 a.m., resident returned from the emergency room with a large hematoma with abrasions to the forehead and a diagnosis of left patella fracture and ankle sprain. Review of Registered Nurse (RN) Employee E1's signed witness statement dated 4/24/26, indicated writer was notified by NA that Resident R1 fell from the wheelchair while being pushed through the door by another NA. Review of NA Employee E2's signed witness statement dated 4/24/26, indicated around 6:00 p.m. as they were coming out of a resident room, the double doors down the middle hallway were opening and NA Employee E3 was pushing Resident R1 through the door and the resident went head (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 0600 Level of Harm - Actual harm Residents Affected - Few	down landing on right side of head and neck. Review of NA Employee E3's signed witness statement dated 4/24/26, indicated Resident R1 was wandering around the ice machine and doorway while writer was getting ice for ice water. All the alarms were going off by the ice machine all the way to the East back hallway. This was the second time writer redirected Resident R1 away from the area to prevent resident from going outside. The last time, the writer redirected Resident R1 they helped to push resident to get to their room. No leg lifts on feet, very hard to push. Resident fell right through the door as writer opened it. Writer indicated they were trying to keep the resident safe from going outside. Review of facility provided report dated 4/24/26, at 6:00 p.m. indicated employee was attempting to redirect resident who was self-propelling in the hallway when they pushed the resident in the wheelchair and the resident fell forward out of the wheelchair. Leg rests were not present on the wheelchair at the time of the incident. Review of Resident Occurrence Report Fall Investigation dated 4/24/26, indicated recommendations to reduce fall or injury in the future: Physical therapy to evaluate for leg rests. Interview on 5/5/26, at 9:00 a.m. NA Employee E4 indicated residents should never be pushed by staff without footrests on the chair. Interview on 5/5/26, at 9:10 a.m. Licensed Practical Nurse (LPN) Employee E5 indicated residents in wheelchairs should always have footrests in place if they are being pushed by staff. Interview on 5/5/26, at 9:15 a.m. NA Employee E6 indicated a resident who self-propels and needs help, staff should go to the resident's room and get the footrests before pushing them. Interview on 5/5/26, at 9:30 a.m. Occupational Therapist Employee E7 indicated when the department provides a resident a wheelchair, they always provide footrests with the chair. Interview on 5/5/26, at 9:45 a.m. NA Employee E8 indicated residents need footrests on the wheelchair before staff can push them. Interview on 5/5/26, at 10:00 a.m. NA Employee E9 indicated staff are not permitted to push a resident in a wheelchair without footrests. Interview on 5/5/26, at 10:42 a.m. RN Employee E1 confirmed NA Employee E3 neglected to place footrests on the wheelchair at the time of the incident on 4/24/26, at 6:00 p.m. while NA Employee E3 was pushing resident through the door, as required which resulted in actual harm of a hematoma to right forehead, left patella fracture, and ankle sprain for Resident R1. Telephonic interview on 5/5/26, at 11:37 a.m. NA Employee E3 indicated Resident R1 maneuvers themselves all over the place in the wheelchair. NA Employee E3 indicated they redirected Resident R1 three times due to the wander guard alarm (device that alerts staff if a resident with a wander bracelet is near an unauthorized area) going off. They pushed Resident R1 back twice while trying to also care for other residents and pass ice water. They reported they were scared because the alarms were going off and they were trying to protect the resident from getting outside. The resident was hard to push, and they opened the door pushing resident through the door and resident fell right on their head. They had to turn all the alarms off and admitted the resident did not have footrests on at the time they pushed the resident through the door. This deficiency is cited as past non-compliance. On 4/24/26, at 8:30 p.m. the facility initiated a plan of correction that included: -The resident involved was immediately assessed following the incident, and appropriate medical evaluation and monitoring were conducted until emergency medics arrived.-The involved staff member received immediate re-education and was sent home during the investigation.-The incident was immediately investigated by the Charge nurse and the Nursing Home Administrator.-Nursing staff have been re-educated on neglect and pushing a resident in a wheelchair must always have footrests in place prior to staff assisting.-All residents were audited and had wheelchair leg rests available and present, at the time of the incident on 4/24/26, at 9:00 p.m. the Shift Supervisor confirmed via verbal report to the Nursing Home Administrator.-All staff were re-educated on wheelchair safety and neglect starting at the time of the incident on 4/24/26.-Education signature sheets were reviewed with staff signatures for 43 of the facility's total 50 employees by 4/27/26.-Wheelchair leg rest bags were ordered to trial with residents who self-propel. Leg rest bags delivered and applied to resident wheelchairs on 5/1/26.-Weekly observation audits conducted to observe compliance with wheelchair transport safety. Results on file with the Nursing Home Administrator reviewed and intact.-Continue with audits to ensure resident (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	safety weekly until 100% (percent) compliance for three months and then will move to monthly observations.-Therapy to continue to monitor Resident R1 for wheelchair seating and option for custom wheelchair.-Observation Audits communicated and provided to QAPI (Quality Assurance and Performance Improvement) Committee. The facility was back in compliance on 4/27/26. Interviews with seven of seven facility staff present on 5/5/26, indicated they received education on neglect and pushing a resident in a wheelchair must always have footrests in place prior to staff assisting. 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 0689 Level of Harm - 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 records and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision and assistance for wheelchair transport to prevent accidents which resulted in actual harm of a hematoma to right forehead, patella (kneecap) fracture, and ankle sprain for one of three residents (Resident R1). This deficiency is cited as past non-compliance. Findings include: Review of the facility policy Fall Prevention dated 7/15/25, indicated a Fall Risk Assessment will be used to screen residents for fall risk on admission, quarterly, annually, and significant change. The nurse will complete the following:Review and complete the variables on the Morse Fall Scale by assigning the corresponding score which best describes the resident. Add the column of numbers to obtain the total score. Scoring as follows:-Hight Risk: 45 and higher-Moderate Risk: 25 - 44-Low Risk 0 - 24.Initiate an intervention(s) as appropriate. Review of the admission record indicated that 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 2/5/26, indicated diagnoses of dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), high blood pressure, and depression. Section C0500 indicated a Brief Interview for Mental Status (BIMS- is a screening test that aids in detecting cognitive impairment) score of 12 - moderately impaired cognition. Section GG - Functional Abilities - Mobility, Question GG0170R indicated the resident was coded at a 03 partial/moderate assistance. Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort for wheeling self 50 feet in a wheelchair and making two turns. Review of Resident R1's Morse Fall Risk Screening dated 4/20/26, indicated a score of 65 - high risk. Review of Resident R1's care plan dated 4/19/26, indicated to provide assistance for ADL's (activities of daily living) as needed. Resident is at risk for falls and related injury due to weakness and history of falling. Goal indicated that resident will not fall, but if a fall occurs, resident will not sustain significant injury through next review. Review of Resident R1's clinical record nursing progress note dated 4/24/26, at 6:57 p.m., indicated writer was alerted by a Nurse Aide (NA) that Resident R1 had fallen from the wheelchair. When approached the resident was found lying on the head with the lower torso up by the wheelchair seat. The NA behind the chair stated they were trying to assist resident through the doors and the resident fell forward. Resident was assessed and noted to have a hematoma (collection of blood outside of the vessels causing swelling, pain and inflammation) to the right forehead. Measured 2.5 centimeters (cm) long by 6 cm wide. Site was bleeding. Resident also had an abrasion to the right knee that was bleeding 2cm long by 2cm wide. Resident complained of head pain. 911 was called and resident was transferred to the emergency room. Further review of Resident R1's clinical record nursing progress note dated 4/25/26, at 1:05 a.m., resident returned from the emergency room with a large hematoma with abrasions to the forehead and a diagnosis of left patella fracture and ankle sprain. Review of Registered Nurse (RN) Employee E1's signed witness statement dated 4/24/26, indicated writer was notified by NA that Resident R1 fell from the wheelchair while being pushed through the door by another NA. Review of NA Employee E2's signed witness statement dated 4/24/26, indicated around 6:00 p.m. as they were coming out of a resident room, the double doors down the middle hallway were opening and NA Employee E3 was pushing Resident R1 through the door and the resident went head down landing on right side of head and neck. Review of NA Employee E3's signed witness statement dated 4/24/26, indicated Resident R1 was wandering around the ice machine and doorway while writer was getting ice for ice water. All the alarms were going off by the ice machine all the way to the east back hallway. This was the second time writer redirected Resident R1 away from the area to prevent resident from going outside. The last time, the writer redirected Resident R1 they helped to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	push resident to get to their room. No leg lifts on feet, very hard to push. Resident fell right through the door as writer opened it. Writer indicated they were trying to keep the resident safe from going outside. Review of facility provided report dated 4/24/26, at 6:00 p.m. indicated employee was attempting to redirect resident who was self-propelling in the hallway when they pushed the resident in the wheelchair and the resident fell forward out of the wheelchair. Leg rests were not present on the wheelchair at the time of the indecent. Review of Resident Occurrence Report Fall Investigation dated 4/24/26, indicated recommendations to reduce fall or injury in the future: Physical therapy to evaluate for leg rests. Interview on 5/5/26, at 9:00 a.m. NA Employee E4 indicated residents should never be pushed by staff without footrests on the chair. Interview on 5/5/26, at 9:10 a.m. Licensed Practical Nurse (LPN) Employee E5 indicated residents in wheelchairs should always have footrests in place if they are being pushed by staff. Interview on 5/5/26, at 9:15 a.m. NA Employee E6 indicated a resident who self-propels and needs help, staff should go to the resident's room and get the footrests before pushing them. Interview on 5/5/26, at 9:30 a.m. Occupational Therapist Employee E7 indicated when the department provides a resident a wheelchair, they always provide footrests with the chair. Interview on 5/5/26, at 9:45 a.m. NA Employee E8 indicated residents need footrests on the wheelchair before staff can push them. Interview on 5/5/26, at 10:00 a.m. NA Employee E9 indicated staff are not permitted to push a resident in a wheelchair without footrests. Interview on 5/5/26, at 10:10 a.m. RN Employee E1 confirmed NA Employee E3 failed to provide adequate supervision and assistance by not placing foot rests on the wheelchair at the time of the incident on 4/24/26, at 6:00 p.m. when they were pushing the resident through the door, as required which resulted in actual harm of a hematoma to right forehead, left patella fracture, and ankle sprain for Resident R1. Telephonic interview on 5/5/26, at 11:37 a.m. NA Employee E3 indicated Resident R1 maneuvers themselves all over the place in the wheelchair. NA Employee E3 indicated they redirected Resident R1 three times due to the wander guard alarm (device that alerts staff if a resident with a wander bracelet is near an unauthorized area) going off. They pushed Resident R1 back twice while trying to also care for other residents and pass ice water. They reported they were scared because the alarms were going off and they were trying to protect the resident from getting outside. The resident was hard to push, and they opened the door pushing resident through the door and resident fell right on their head. They had to turn all the alarms off and admitted the resident did not have footrests on at the time they pushed the resident through the door. This deficiency is cited as past non-compliance. On 4/24/26, at 8:30 p.m. the facility initiated a plan of correction that included: -The resident involved was immediately assessed following the incident, and appropriate medical evaluation and monitoring were conducted until emergency medics arrived.-The involved staff member received immediate re-education and was sent home during the investigation.-The incident was immediately investigated by the Charge nurse and the Nursing Home Administrator.-Nursing staff have been re-educated on neglect and pushing a resident in a wheelchair must always have footrests in place prior to staff assisting.-All residents were audited and had wheelchair leg rests available and present, at the time of the incident on 4/24/26, at 9:00 p.m. the Shift Supervisor confirmed via verbal report to the Nursing Home Administrator.-All staff were re-educated on wheelchair safety and neglect starting at the time of the incident on 4/24/26.-Education signature sheets were reviewed with staff signatures for 43 of the facility's total 50 employees by 4/27/26.-Wheelchair leg rest bags were ordered to trial with residents who self-propel. -Leg rest bags delivered and applied to resident wheelchairs on 5/1/26.-Weekly observation audits conducted to observe compliance with wheelchair transport safety. Results on file with the Nursing Home Administrator reviewed and intact.-Continue with audits to ensure resident safety weekly until 100% (percent) compliance for three months and then will move to monthly observations.-Therapy to continue to monitor Resident R1 for wheelchair seating and option for custom wheelchair.-Observation Audits communicated and provided to QAPI (Quality Assurance and Performance Improvement) Committee. The facility was back in compliance on 4/27/26. Interviews with seven of seven facility staff present on 5/5/26, indicated they received education on neglect and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	pushing a resident in a wheelchair must always have footrests in place prior to staff assisting. 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.