STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395603	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring Heights Community Care & Rehab Ctr	234 Coraopolis Road Coraopolis, PA 15108

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 facility policy, 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 (discharged Resident R1) and failed to notify the resident representative of a change in condition requiring a hospital transfer for one of three residents (Resident R3).Findings include: Review of facility policy Resident Change in Condition last reviewed 5/26/26, indicated:The facility will inform the resident; consult with the resident's physician/provider; and notify the resident representative(s) when there is: a) An accident involving the resident which results in injury and has the potential for requiring physician/provider intervention; b) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);c) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); d) A decision to transfer or discharge the resident from the facility;The nurse will record information related to the change in condition and subsequent events and notifications in the resident's health record. Review of the clinical record revealed discharged Resident R1 was admitted to the facility on [DATE]. Review of discharged Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/22/26, indicated diagnoses of coronary artery disease (CAD- arteries that supply blood to the heart become narrowed or blocked) hypertension (high blood pressure) and diabetes (high sugar in the blood) Review of discharged Resident R1's clinical record revealed a progress note dated 5/24/26, at 7:33 a.m. that indicated resident complained of chest pain and pressure; vitals were taken and the heart rate was 113 beats per minute, other vitals were within normal limits. Head of bed was elevated; deep breathing exercise was encouraged, and Tylenol (650mg) was administered. She was closely monitored and she said she had been relieved after about thirty minutes. The clinical record failed to reveal that the physician was notified of discharged Resident R1's change in condition. During an interview completed on 6/2/26, at 12:12 p.m. the Director of Nursing (DON) confirmed that the facility failed to notify the physician for a change in condition for discharged Resident R1. Review of the clinical record revealed Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS dated [DATE], indicated diagnosis of heart failure (the heart doesn't pump as well as it should), hypertension (high blood pressure) and Parkinsons disease (brain disorder that causes problems with movement). Section C 0500 Brief Interview for Mental Status (BIMS- is a short cognitive screening tool used to assess memory, thinking, and orientation to time) coded as 11 moderate cognitive impairment. Review of Resident R3's nursing progress notes dated 5/21/26, at 11:00 p.m. revealed resident reported that she fell off her bed and hit her head on something hard and got herself up off the floor unassisted. Her roommate confirmed that was what happened. Vital signs are stable, within normal limits. She is complaining of a light headache. Physician notified and recommended that resident be sent to the hospital for evaluation. Resident agreeable to be transferred to the hospital. 911 called, awaiting EMS. The clinical record failed to reveal that Resident R3's representative was notified of the event and the (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospital transfer. Review of Resident R3's clinical record face sheet revealed her is niece listed as emergency contact one, the niece's primary phone number and work phone number were also provided. During an interview completed on 6/2/26, at 2:02 p.m. Upon asking Resident R3 if she could recall a day in which she went to the hospital replied yes upon asking if she had a representative that she has designated to be notified of any changes or the need to be transferred to hospital said replied yes my niece. During an interview completed on 6/2/26, at 2:05 p.m. the Regional Director of Clinical Services Employee E2 stated Resident R3 is listed as her own representative that is why her niece was not called. During an interview completed on 6/2/26, at 2:08 p.m. the Director of Nursing confirmed that Resident R3's representative was not contacted upon resident R3's transfer to the hospital for evaluation after a fall and that the facility failed to notify the resident representative of a change in condition requiring a hospital transfer for one of three residents (Resident R3). 28 Pa. Code: 211. 12(d)(1) Nursing services.

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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 notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for one of three residents (discharged Resident R1).Findings include: Review of the facilities Bed Hold Policy last reviewed 5/26/26, indicated It is the policy of the facility to track Medicaid bed hold days and notify appropriate parties via Medicaid Bed Hold Letter. Business Office or designee will complete the Medicaid Bed Hold Letter and send to the appropriate parties' certified/return receipt requested. The Medicaid Bed Hold Letter can be given directly to the responsible party if they are present. Medicaid Copy will be retained in resident's financial file. Review of the clinical record revealed discharged Resident R1 was admitted to the facility on [DATE]. Review of discharged Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/22/26, indicated diagnoses of coronary artery disease (CAD-arteries that supply blood to the heart become narrowed or blocked) hypertension (high blood pressure) and diabetes (high sugar in the blood). Review of discharged Resident R1's physician orders dated 5/24/26, at 5:38 p.m. indicated okay to send to hospital for evaluation. Review of discharged Resident R1's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 5/24/26. During an interview completed on 6/2/26, at 2:08 p.m. the Director of Nursing confirmed that discharged Resident R1's clinical record failed to include evidence that the resident or resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 5/24/26. 28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **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 failed to document vital signs for a one of three residents with a change in condition (discharged Resident R1) failed to follow a physician order for one of three residents (discharged Resident R1) and failed to obtain physician orders for a hospital transfer for one of three residents (Resident R4).Findings include: Review of facility policy Resident Change in Condition last reviewed 5/26/26, indicated:The facility will inform the resident; consult with the resident's physician/provider; and notify the resident representative(s) when there is: a) An accident involving the resident which results in injury and has the potential for requiring physician/provider intervention; b) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);c) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); d) A decision to transfer or discharge the resident from the facility;The nurse will record information related to the change in condition and subsequent events and notifications in the resident's health record. Review of the clinical record revealed discharged Resident R1 was admitted to the facility on [DATE]. Review of discharged Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/22/26, indicated diagnoses of coronary artery disease (CAD- arteries that supply blood to the heart become narrowed or blocked) hypertension (high blood pressure) and diabetes (high sugar in the blood) Review of discharged Resident R1's physician orders dated 5/16/26, indicated thoracolumbosacral orthosis (TLSO-brace used to limit motion and promote healing in the thoracic, lumbar and sacral region of the spine) at all times when out of bed. Review of discharged Resident R1's clinical record revealed a progress note dated 5/24/26, at 7:33 a.m. that indicated resident complained of chest pain and pressure; vitals were taken and the heart rate was 113 beats per minute, other vitals were within normal limits. Head of bed was elevated; deep breathing exercise was encouraged, and Tylenol (650mg) was administered. She was closely monitored and she said she had been relieved after about thirty minutes. The clinical record failed to reveal the vital sign measurements that were within normal limits. During an interview completed on 6/2/26, at 12:12 p.m. the Director of Nursing (DON) confirmed that the facility failed to document vital signs for discharged Resident R1 with a change in condition of chest pain and pressure. Review of discharged Resident R1's clinical record revealed that on n 5/24/26, at 2:55 p.m. Resident was lowered to the floor by 2 staff members when transferring off the commode. The physician and husband were notified. Resident R1's range of motion remained as prior and no new complaints of increased pain. Post fall monitoring was ordered with special instructions if a change is noted from the resident's baseline complete a change in condition. During an interview completed on 6/2/26, at 11:40 a.m. the Assistant Director of Nursing (ADON) Employee E8 revealed that she was called to discharged Resident R1's restroom by the nurse aids that informed her that discharged Resident R1 was sliding while getting off the toilet. ADON Employee E8 also added that she helped the resident with positioning to get on her side on the floor. The resident was then assisted to a standing position. ADON Employee E8 did reveal that discharged Resident R1 had a non-weight bearing status to her left arm, her left arm was wrapped at the time, no other appliances where on at the time, then stated maybe a neck brace, I can't picture it right now, she did have non slip socks on and was able to stand on her own with assistance, she had no new complaints during the assessment. During a telephonic interview completed on 6/2/26, at 12:00 p.m. Nurse Aid (NA) Employee E6 revealed that the incident occurred on the daylight shift and stated that she along with another NA was transferring discharged Resident R1 from the toilet to the wheelchair and her knee must have buckled as we lowered her to the floor. NA Employee E6 further replied discharged Resident R1 went to her side and she went to get the nurse, NA Employee E6 further stated that she (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was up off the toilet and was about to pivot that's when her knee buckled, she had a walker and a wheelchair Upon further inquiry it was revealed that NA Employee E6 was aware of the transfer of 2 staff, she also stated she had a neck brace on and her arm was in a sling. Upon asking NA Employee E6 concerning a back brace replied, not that I am aware of. During an interview completed with NA Employee E7 concerning the events that took place with discharged Resident R1 stated NA Employee E6 came to get me to take her off the toilet, she was trying to get to her walker but she kind of started to slide down, we couldn't hold her, so we lowered her to the floor NA Employee E6 went to get the nurse. Upon asking if any equipment was used by discharged Resident R1 replied, she had a neck brace and a sling on. Upon asking concerning a back brace replied, There was no back brace. During an interview completed on 6/2/26, at 12:12 p.m. the DON confirmed that discharged Resident R1's TLSO brace was not on when discharged Resident R1 was lowered to the floor and that the facility failed to follow a physician order for one of three residents (discharged Resident R1) Review of the clinical record revealed Resident R4 was admitted to the facility on [DATE], with the diagnosis of Chronic Obstructive Pulmonary Disease (COPD-makes it hard to breathe) hypertension (high blood pressure) and anxiety. Review of Resident R4's progress notes dated 4/28/26 at 3:34 a.m. indicated resident fell attempting to transfer from wheelchair to toilet and stated that she lost her footing. Resident was assisted back into her wheelchair with the assist of 2. Resident is alert and oriented x4 and stated that she hit her head and had back pain radiating into her chest. Tylenol administered. Resident requested to go to the emergency room for evaluation. Review of Resident R4's physician orders failed to reveal an order for Resident R4's transfer to the hospital. During an interview completed on 6/2/26, at 2:08 p.m. the DON confirmed that the facility failed to obtain physician orders for a hospital transfer for one of three residents (Resident R4). 28 Pa. Code 211.12(d)(1)(5) Nursing services.