STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395666	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Hill Rehabilitation and Nursing Center	2170 Rhine Street Pittsburgh, PA 15212

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to accommodate the proper linen needs for three of five residents (Residents R2, R3, and R9). Findings include: A review of facility policy Safe and Homelike Environment dated 12/9/24, indicated in accordance with residents ' rights, the facility will provide a safe, clean, comfortable and homelike environment. This includes ensuring that the resident can receive care and services safely. Environment includes any environment in the facility that is frequented by residents, including, but not limited to, the residents' room, bathrooms, hallway, dining area. A review of facility policy Accommodation of Needs dated 12/9/24, indicated the facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodations for the individual needs and preferences of a resident, except when the health and safety of the individual or other residents would be endangered. During a tour of the facility on 7/1/25, at 9:03 a.m. the clean linen rack on the first floor failed to have any towels or wash towels on the rack for use. During an interview on 7/1/25, at 9:26 a.m. Nursing Assistant (NA) Employee E2 stated that the facility does not have enough towels and wash towels to be able to wash residents and stated I have to pick and choose sometimes as to who is going to get washed. It's sad to say but I have to prioritize residents as to who I wash up and who I don't. That's not right and it's not my fault. During an interview on 7/1/25, at 10:01 a.m. NA Employee E3 stated When I got here at seven o clock today, there were no towels or wash towels on the linen rack. I went to laundry and was able to get around eight towels and six wash towels for 30 residents. NA Employee E3 stated that facility does not have enough linen to provide care to the residents. I can only wash up certain residents. During an observation on 7/1/25, at 11:14 a.m. clean utility cart was stocked with six towels and two wash towels. Review of clinical record indicated Resident R2 was admitted to the facility on [DATE]. (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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/18/25, indicated diagnoses of high blood pressure, depression, and heart failure (a progressive heart disease that affects pumping action of the heart muscles). During an interview on 7/1/25, at 1:11 p.m. Resident R2 stated she got washed up herself a little bit but did not have any towels or wash towels. Resident R2 stated I had to use paper towels. Review of clinical record indicated Resident R3 was admitted to facility on 1/2/25. Review of Resident R2's MDS dated [DATE], indicated diagnoses of depression, coronary artery disease (damage or disease in the heart's major blood vessels), depression, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). During an observation on 7/1/25, at 1:20 p.m. a towel and wash towel was hanging on the foot board of his bed. During an interview on 7/1/25, at 1:22 p.m. Resident R3 stated that he got cleaned up by himself using the towels observed on his foot board of his bed. Resident R3 stated I used them yesterday to, they were dirty, but I didn't have any other ones to use. I don't get cleaned up sometimes because they don't have towels or wash towels. During a tour of the facility on 7/1/25, at 9:13 a.m. the clean linen rack on the second floor had one half torn wash cloth on the rack for use and no towels. During a tour of the facility on 7/1/25, at 9:18 a.m. the clean linen rack on the second floor by room [ROOM NUMBER] had two towels and no washcloths. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of Resident R9's MDS dated [DATE], indicated seizure disorder (a person experiences abnormal behaviors, symptoms and sensations, sometimes including loss of consciousness), chronic pain, and osteoarthritis (flexible tissue at the ends of bone wears down). During an interview on 7/1/25, at 9:21 a.m. Resident R9 indicated the only concern they had was there are not enough towels and washcloths. When asked what they use when they run out, Resident R9 indicated those disposable wipes, they are like paper towels. Resident R9 indicated I'd offer to pay more money if it would help them order linens. During a tour of the laundry room on 7/1/25, at 9:46 a.m. the clean rack of linen that was being prepared to send to the units for a total of 70 residents included 12 towels and 10 washcloths. During an interview on 7/1/25, at 9:48 a.m. Environmental Service (ES) Employee E10 and ES Employee E11 indicated they arrive at 7:00 a.m. to linen in the washers and everything that soiled. There are two washers and only one dryer working at this time. During a tour and interview of the laundry room with the Nursing Home Administrator on 7/1/25, at 9:50 a.m. the amount of linen available on the cart was confirmed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/1/25, at 3:00 p.m. Nursing Home Administrator confirmed that the facility failed to accommodate the proper linen needs for three of five residents (Residents R2, R3, and R9). 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility documents, observations, and staff interviews, it was determined that the facility failed to maintain a homelike environment for one of two floors (First Floor). Findings include: A review of facility policy Safe and Homelike Environment dated 12/9/24, indicated in accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment. This includes ensuring that the resident can receive care and services safely. Environment includes any environment in the facility that is frequented by residents, including, but not limited to, the residents' room, bathrooms, hallway, dining area. During a tour of the unit on 7/1/25, at 8:58 a.m. the following were observed: - room [ROOM NUMBER] - Hole in the wall located by the air conditioner unit - room [ROOM NUMBER] - Bathroom vent had dust build up, bathroom plaster on the ceiling was peeling - room [ROOM NUMBER] - Bathroom vent had dust build up - room [ROOM NUMBER] - Bathroom plaster on the ceiling was peeling - room [ROOM NUMBER] - Bathroom vent had dust build up, bathroom ceiling patched but not fixed with brown stains, and bathroom wallpaper peeling. - room [ROOM NUMBER] - Bathroom vent had dust build up and bathroom had brown stains on the ceiling - East Wing Shower - Observed a sign on the door that stated Do not use at all on the door. In the shower room, above a shower stall, a part of the ceiling had plastic duct taped up to the ceiling to cover an opening and the light fixture was improperly hanging. - [NAME] wing fire pull station was not secured to the wall and had unpainted plaster directly behind it. During a tour of the unit on 7/1/25, at 10:21 a.m. Registered Nurse (RN) Employee E1 confirmed the above findings. During an interview on 7/1/25, at 3:00 p.m. Nursing Home Administrator confirmed that the facility failed to maintain a homelike environment for one of two floors (First Floor). 28 Pa. Code: 201.18(b)(3) Management

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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, facility documents, clinical records, and resident and staff interviews, it was determined that the facility failed to make certain residents were free from neglect and mistreatment by giving the wrong medication to a resident after resident refusal for one of three residents (Resident R4). Findings include: The facility policy Abuse, Neglect, Mistreatment Education dated 12/9/24, indicated the facility prohibits mistreatment, neglect, and abuse of residents by anyone including staff, family friends, etc. Neglect - Failure to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect of goods or services may occur when staff are aware, or should be aware, of residents' care needs, but are unable to get the identified needs due to other circumstances, such as lack of training to perform an intervention, lack of supplies, or lack of staff knowledge of the needs of the resident. Review of the facility policy Medication Administration dated 12/9/24, indicated if a dose of medication is refused the physician and the responsible party will need to be notified. A reason is documented in a progress note. Review of admission record indicated Resident R4 admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/3/25, indicated the diagnoses of renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), sepsis (a life-threatening complication of an infection), and lymph edema (swelling in an arm or leg caused by a lymphatic system blockage). Review of facility provided documentation dated 6/24/25, indicated Resident R4's family reported to nurse that resident had been given insulin on 6/24/25, at approximately 12:56 p.m. Director of Nursing received notification on 6/25/25, at 7:30 a.m. Vitals and blood sugar taken and were within normal limits. Provider notified of alleged medication error and ordered vital signs and blood sugar checks every three hours for 24 hours. Nurse wrote statement stating that she gave Resident R4 insulin on 6/24/2025. Further review of the facility provided documentation dated 6/24/25, indicated Resident R4 does not have diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), is not ordered insulin, and received a long-acting insulin (either Lantus or Soliqua which is a combination of Lantus and a GLP-1 agonist) at approximately 12:56 p.m. on 6/24/25, of an unknown amount. Review of Register Nurse (RN) Employee E5's signed witness statement dated 6/25/24, indicated that RN gave her insulin, after meeting Resident R4 again on 6/25/25, with administration, RN confirmed that they in fact did give Resident R4 insulin and admitted to a medication error. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 7/1/25, at 1:00 p.m. the Director of Nursing indicated RN Employee E5 admitted to giving the insulin to Resident R4, despite her verbal refusal. (Resident R4 speaks minimal English and speaks primarily French). The Director of Nursing confirmed the insulin was given against the resident's wishes. Review of Resident R4's progress notes dated 6/25/25, at 7:00 a.m. indicated upon start of today's shift Licensed Practical Nurse (LPN) Employee E1 was made aware by staff members that Resident R4 had received insulin yesterday morning. This nurse immediately assessed resident and confirmed via translator (device use to translate different languages) that resident had received insulin. Resident appears to have no physical distress but is afraid of any potential side effects. Interview on 7/1/25, at 10:10 a.m. LPN Employee E6 indicated to verify who a resident was they would check the photo in the computer. Interview on 7/1/25, at 10:20 a.m. LPN Employee E7 indicated they would check the photo in the computer, ask another staff member, or ask the resident their name. Interview on 7/1/25, at 11:00 a.m. LPN Employee E8 indicated they identify the residents by name, were unsure if all residents have an ID band with their name on, but there are pictures in the computer and names on the doors. Interview on 7/1/25, at 11:14 a.m. RN Employee E1 indicated they do not have arm bands, but have pictures in the computer, names on the wall, and ask the residents who they are. Interview on 7/1/25, at 4:00 p.m. the Director of Nursing confirmed the facility failed to make certain residents were free from neglect and mistreatment by proceeding to give a worng medication to a resident after refusal for one of three residents (Resident R4). 28 Pa. Code: 201.14(c) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 201.19(6) Personnel policies and procedures. 28 Pa. Code: 201.20(a)(1)(5)(b)(d) Staff development. 28 Pa. Code: 201.29(a) Resident rights.

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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 policies, resident records and staff interview, it was determined the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for one of three residents (Resident R5). Finding include: Review of the facility policy Transfer and Discharge (including AMA) dated 12/9/24, indicated for a transfer to another provider, for any reason, the following information must be provided to the receiving provider: specific information to the receiving health care provider which includes the resident's care plan goals, advanced directive information, specific instructions for ongoing care, and all information necessary to meet the resident's specific needs at the receiving facility. 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 4/3/25, indicated the diagnosis of stroke (damage to the brain from an interruption of blood supply), diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and high blood pressure. Section K0520-B indicated feeding tube for greater than 51% of total calories and greater than 500 milliliters of fluids received via the tube. Review of Resident R5's progress notes dated 6/19/25, at 10:48 a.m. indicated resident is being transferred to local hospital to have a gastro tube (a tube inserted through the abdomen into the stomach used for long-term feeding and medications) replaced. Review of Resident R5's clinical record revealed no documented evidence that the facility had communicated in writing 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, and all information necessary to meet the resident's specific needs at the receiving facility. Interview on 7/1/25, at 12:38 p.m. the Director of Nursing confirmed the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for one of three residents (Resident R5). 28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, observations, and staff interview, it was determined the facility failed to provide to provide appropriate care and services to residents receiving tube feedings for four of five residents reviewed (Residents R6, R7, R5, and R8) and failed to adhere to tube site dressing care for one of four residents (R8). Findings include: Review of the facility policy Care and Treatment of Feeding Tubes (delivery of food or medication via tube surgically inserted into stomach) dated 12/9/24, indicated the facility must utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Review of the facility policy Enteral Medication Administration dated 12/9/24, indicated to reconnect tube or clamp as indicated. Rinse the syringe and allow it to air dry. Store in a plastic bag. Change syringe every 24 hours. Review of the clinical record revealed that Resident R6 was admitted to the facility on [DATE], with the diagnoses of Adult Failure to Thrive (the end stage of frailty syndrome, a broader term for age-related decline), hypothyroid (thyroid gland doesn't produce enough thyroid hormone), and glaucoma (a group of eye conditions that can cause blindness). Review of Resident R6's physician orders dated 4/15/25, indicated Osmolite 1.5 (a nutritional supplement) via pump at 95 cc/hr (cubic centimeters/hour) for 16 hours daily for total of 1520 mls (milliliters). Observation on 7/1/25, at 8:58 a.m. Resident R6 was observed in bed. The pole holding the feeding tube pump was dirty with dried tube feeding substance on the base. A cup with unknown fluid on windowsill, stained dried feeding substance. Review of the clinical record revealed that Resident R7 was admitted to the facility on [DATE], with diagnoses of traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head), convulsions (sudden, violent, irregular movement of a limb or the entire body caused by a brain disorder), and progressive neuropathy (peripheral nerve damage worsens over time). Review of Resident R7's physician orders dated 4/15/25, indicated water flush via G-tube 60 milliliters every shift to maintain patency. Observation on 7/1/25, at 9:08 a.m. Resident R7's bedside stand had a cup with liquid in it along with a syringe that was not air drying or in a plastic bag as directed. Review of the clinical record revealed that Resident R5 was admitted to the facility on [DATE], with diagnoses of stroke (damage to the brain from an interruption of blood supply), hemiplegia (paralysis of one side of the body), and (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Convulsions. Review of Resident R5's physician orders dated 6/26/25, indicated Glucerna 1.2 (nutritional supplement) via G-tube at 80 ml/hr for 20 hours a day for a total volume of 1600 mls. Start at noon and stop at 8:00 a.m. Observation on 7/1/25, at 9:13 a.m. Resident R5 was lying in bed with a blue printed shirt on. The feeding pump beside the bed was turned off and the feeding bag tubing was still connected to the G-tube. Syringe was noted in a large Styrofoam cup, no date, sitting in water. Not air drying or in a plastic bag as required. Review of the clinical record revealed that Resident R8 was admitted to the facility on [DATE], with diagnoses of systemic lupus (immune system attacks health tissues and organs), fibromyalgia (a long-term condition that involves widespread body pain and tiredness), and history of traumatic brain injury. Review of Resident R8's current physician orders indicated Osmolite 1.2 continuous via pump at 70 ml/hr for 20 hours per day or for total volume of 1400 mls. Up at 12:00 p.m. and down at 8:00 a.m. Change G-tube site with normal saline, pat dry, and apply clean drain sponge every day shift. Observation on 7/1/25, at 9:18 a.m. Resident R8 was lying in bed with her hands around upper body exposing the abdominal area underneath the shirt. The G-tube drain dressing was noted to have a date of 6/29/25. The floor in the room beside the bed had liquid, fresh tube feeding and water substance all over the floor, two cups on the floor, the pump was dirty with dried feeding. Tour and interview on 7/1/25, at 9:52 a.m. the Director of Nursing confirmed the above findings relating to the syringes not stored properly, dried and wet feeding stains in rooms, and that the drain sponge for Resident R8 was not changed per resident's physician orders. Interview on 7/1/25, at 4:00 p.m. the Director of Nursing confirmed the facility failed to provide to provide appropriate care and services to residents receiving tube feedings for four of five residents reviewed (Residents R6, R7, R5, and R8) and failed to adhere to tube site dressing care for one of four residents (R8). 28 Pa. Code: 201.18(b)(1)(2) Management. 28 Pa. Code: 211.12(d)(1)(5) Nursing services. 28 Pa. Code: 211.10(c) Resident care policies.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observation, clinical record, and staff interview, it was determined that the facility failed to make certain that residents are free of significant medication errors for one of three residents (Resident R4). Findings include: Review of the facility policy Medication Administration dated 12/9/24, indicated medications are administered by licensed nurses, as ordered by the physician and in accordance with professional standards or practice. Identify resident by photo in the Medication Administration Record (MAR). Review MAR to identify medication to be administered. Compare medication source (pack, vial, etc.) with MAR to verify resident's name medication name, form, dose, route, and time. Administer medication as ordered. Sign MAR after administration. Review of the facility policy Medication Administration dated 5/1/24, indicated medications ordered for one resident are never administered to another resident. Review of admission record indicated Resident R4 admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/3/25, indicated the diagnoses of renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), sepsis (a life-threatening complication of an infection), and lymph edema (swelling in an arm or leg caused by a lymphatic system blockage). Review of facility provided documentation dated 6/24/25, indicated Resident R4's family reported to nurse that resident had been given insulin on 6/24/25, at approximately 12:56 p.m. Director of Nursing received notification on 6/25/25, at 7:30 a.m. Vitals and blood sugar taken and were within normal limits. Provider notified of alleged medication error and ordered vital signs and blood sugar checks every three hours for 24 hours. Nurse wrote statement stating that she gave Resident R4 insulin on 6/24/2025. Further review of the facility provided documentation dated 6/24/25, indicated Resident R4 does not have diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), is not ordered insulin, and received a long-acting insulin (either Lantus or Soliqua which is a combination of Lantus and a GLP-1 agonist) at approximately 12:56 p.m. on 6/24/25, of an unknown amount. Interview on 7/1/25, at 11:00 a.m. the Director of Nursing confirmed the facility failed to make certain that residents are free of significant medication errors for one of three residents (Resident R4). 28 Pa. Code: 211.10(c.)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review, observation, and staff interviews, it was determined that the facility failed to prevent cross contamination with residents' personal toiletries for two of five bathrooms on the First Floor (Rooms 107, and 118). Findings include: A review of facility policy Safe and Homelike Environment dated 12/9/24, indicated in accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment. This includes ensuring that the resident can receive care and services safely. Environment includes any environment in the facility that is frequented by residents, including, but not limited to, the residents' room, bathrooms, hallway, dining area. A review of facility policy Infection Prevention and Control Programs dated 12/9/24, indicated the facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. During a tour of the facility on 7/1/25, at 8:58 a.m. the following were observed: - room [ROOM NUMBER] - Resident bathroom had unlabeled deodorant, skin protectant, body wash, shampoo, and toothpaste in the bathroom that is shared by multiple residents. - room [ROOM NUMBER] - Resident bathroom had unlabeled body wash, shampoo, and peri-wash cleanser in the bathroom that is shared by multiple residents. During an interview on 7/1/25, at 9:37 a.m. Nursing Assistant (NA) Employee E2 stated that residents should have their own toiletries with their names on it and should not be kept in the bathroom. Sometimes we run out of supplies, and we have to share items between the residents. During an interview on 7/1/25, at 10:15 a.m. NA Employee E3 stated that residents are to have their own items, marked with their names and should not be shared amongst each other. During an interview on 7/1/25, at 3:00 p.m. Nursing Home Administrator confirmed that the facility failed to prevent cross contamination with residents' personnel toiletries for two of five bathrooms on the First Floor (Rooms 107, and 118). 28 Pa. Code: 211.10(d) Resident Care Policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing Services.