

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395666	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Spring Hill Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, resident and staff interviews, it was determined that the facility failed to afford residents the right to self-administer medication for one of three residents (Resident R1). Findings include: Review of facilities Resident Right policy dated 9/22/25, indicated the facility will inform the resident both orally and in writing of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Residents have the right to participate in planning and implementing care. Residents have the right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate. Review of facilities Self-Administration by Resident policy dated 9/22/25, indicated the residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe and the medications are appropriate and safe for self-administration. Review of Resident R1's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R1's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 10/29/25, indicated diagnoses of hypertension (high blood pressure in the arteries), anxiety, and irritable bowel syndrome (a digestive disorder that affects the large intestines). Resident R1's MDS assessment section C0200 Brief Interview for Mental Status (BIMS, a screening test that aides in detecting cognitive impairment). The BIMS total score suggests the following distributions: 13-15: cognitively intact, 8-12: moderately impaired, 0-7: severe impairment. Resident R1's BIMS score was 15 indicating Resident R1 was cognitively intact. During an interview on 11/19/25, at 1:05 p.m. Resident R1 revealed that he has requested to self-administer his own medications multiple times to nursing staff. Resident R1 stated he understands the facility must make sure he is competent prior to allowing him and that he already has a locked drawer. During a clinical record review on 11/19/25, at 1:20 p.m. no documentation was completed that indicated the facility followed necessary steps to afford Resident R1 a right to self-administer his own medication. During an interview on 11/19/25, at 1:35 p.m. the Director of Nursing (DON) stated We don't do that. I know there is a lot of paperwork with it. Nobody had been doing it beforehand. No one self-administers medication. During an interview on 11/19/25, at 1:40 p.m. the DON confirmed that the facility failed to afford residents the right to self-administer medication for one of three residents (Resident R1). 28 Pa. Code 201.29(a) Resident rights</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations and staff interview it was determined that the facility failed to provide a clean, safe, comfortable, and homelike environment for 12 out of 15 resident rooms (Rooms 102, 107, 114, 116, 119, 204, 206, 208, 216, 224, 225, and 226), and one out of two resident common rooms (Second Floor). Findings include: Review of facility Safe and Homelike Environment policy dated 9/22/25, indicated in accordance with residents' rights, the facility will provide a safe, clean, comfortable, homelike environment. This includes ensuring that the residents can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. During a tour of the facility on 11/19/25, at 10:00 a.m. with Licensed Practical Nurse (LPN) Employee E1 the following were observed: Resident room [ROOM NUMBER]'s bathroom failed to have a working and functional hand soap dispenser. Resident room [ROOM NUMBER]'s bathroom failed to have a working and functional hand soap dispenser. Resident room [ROOM NUMBER]'s bathroom failed to have a working and functional hand soap dispenser. Resident room [ROOM NUMBER]'s bathroom failed to have a working and functional hand soap dispenser. Resident room [ROOM NUMBER]'s bathroom failed to have a working and functional hand soap dispenser. During an interview on 11/19/25, at 10:35 a.m. LPN Employee E1 confirmed the above findings. During a tour of the facility on 11/19/25, at 11:12 a.m. with Registered Nurse (RN) Employee E2 the following were observed: Resident room [ROOM NUMBER]'s bathroom failed to have a working and functional hand soap dispenser. Resident room [ROOM NUMBER]'s bathroom failed to have a working and functional hand soap dispenser. Resident room [ROOM NUMBER]'s bathroom failed to have a working and functional hand soap dispenser. Resident room [ROOM NUMBER]'s bathroom failed to have a working and functional hand soap dispenser. During an observation on 11/19/25, at 11:20 a.m. the Second-Floor Resident Common area contained three empty medication carts, one Hoyer lift, two wheelchairs, and the floor had dirt and debris all throughout. During an interview on 11/19/25, at 11:22 a.m. RN Employee E2 confirmed the above findings. During a tour of the facility on 11/19/25, at 1:00 p.m. with the Nursing Home Administrator (NHA) the following were observed: Resident room [ROOM NUMBER], 225, and 226 did not have residents occupying these rooms. The mattresses on the beds were stained, discolored and ripped in places. During an interview on 11/19/25, at 1:11 p.m. the NHA confirmed the above findings. During an interview on 11/19/25, at 4:00 p.m. the NHA confirmed that the facility failed to provide a clean, safe, comfortable, and homelike environment for 12 out of 15 resident rooms (Rooms 102, 107, 114, 116, 119, 204, 206, 208, 216, 224, 225, and 226), and one out of two resident common rooms (Second Floor). 28 Pa. code: 201.14 (b) Responsibility of licensee. 28 Pa Code: 201.18 (e)(1)(2) Management. 28 Pa Code: 201.29 (a)(c) Resident Rights.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**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 follow a physician order for one out of three residents (Resident R2) and failed to make certain that residents were provided appropriate treatment and care for one of three residents (Residents R1).</p> <p>Findings include:</p> <p>Review of the facility policy Provision of Quality Care dated 9/22/25, indicated based on comprehensive assessments, the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans and the residents' choices.</p> <p>Review of facilities Resident Right policy dated 9/22/25, indicated the facility will inform the resident both orally and in writing of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Residents have the right to participate in planning and implementing care.</p> <p>Review of facilities Accommodation of Needs policy dated 9/22/25, indicated the facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodations for the individual. The facility will assist the residents in maintaining and achieving independent functioning, dignity, and well-being to the extent possible.</p> <p>Review of the admission record indicated Resident R2 was admitted to the facility on [DATE].</p> <p>Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/4/25, indicated the diagnoses of hypertension, renal insufficiency (a condition in which the kidneys lose the ability to remove waste and balance fluids), and heart failure (heart doesn't pump blood as well as it should).</p> <p>Review of Resident R2's current physician orders on 9/30/25, indicated Adalimumab (a medication used to treat various inflammatory conditions) 40mg (milligrams) inject subcutaneously (injection into the fatty tissue layer) once every fourteen days.</p> <p>Review of Resident R2's Medication Administration Record (MAR) dated September 2025, indicated the medication was administered on 9/1/25, and 9/29/25. The medication was not given on 9/15/25.</p> <p>Review of the progress note 9/15/25, at 11:45 a.m. indicated the adalimumab was not given. Physician and family were not notified of the omission.</p> <p>Telephonic Interview on 10/1/25, at 2:00 p.m. the Director of Nursing confirmed the medication was not provided as per the order and that the physician and family were not notified of the omission.</p> <p>Review of Resident R1's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R1's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 10/29/25, indicated diagnoses of hypertension (high blood pressure in the arteries), anxiety, and irritable bowel syndrome (a digestive disorder that affects the large intestines). Resident R1's MDS assessment section C0200 Brief Interview for Mental Status (BIMS, a screening test that aides in detecting cognitive impairment). The BIMS total score suggests the following distributions: 13-15: cognitively intact, 8-12: moderately impaired, 0-7: severe impairment. Resident R1's BIMS score was 15 indicating Resident R1 was cognitively intact.</p> <p>Review of Resident R1's physician orders dated 9/1/25, indicated a follow up appointment to be made with Colo-Rectal surgery center on 11/19/25, at 2:30 p.m.</p> <p>Review of Resident R1's physician orders dated 3/1/25, indicated to take Lomotil (used to treat diarrhea) 2. 5-0.025 milligram tablet by mouth every eight hours as needed for diarrhea, rectal prolapse.</p> <p>Review of Resident R1's Medication Administration Record from November 2025, indicated the resident has received Lomotil 22 times thus far this month.</p> <p>During an interview on 11/19/25, at 1:05 p.m. Resident R1 stated that the Director of Nursing (DON) spoke with him on 11/17/25, and stated the provider cancelled his outside appointments and would be able to wait to go to them after being discharged from the facility.</p> <p>During an interview on 11/19/25, at 1:30 p.m. the DON stated Resident R1 was supposed to go to a Colo-rectal appointment on this date, and it was cancelled because the provider wanted the facility to figure out where resident is at in the nursing transitions program. The resident does not have a discharge date . All appointments are on hold, and the resident is not going to any. DON stated, The facility is paying \$150.00 a day to send him somewhere, he has lots of appointments.</p> <p>During a phone interview on 11/19/25, at 3:05 p.m. the Certified Registered Nurse Practitioner (CRNP) Employee E3 stated the only appointment that should have been cancelled was the outside physical therapy at this time. No other appointments should have been cancelled. When asked if he should have went to the Colo-rectal appointment on 11/19/25 per physician order, CRNP replied, Yes, he should have went to that appointment.</p> <p>During an interview on 11/19/25, at 4:01 p.m. the DON stated that Resident R1 follow up appointments will be reordered by the physician and confirmed that the failed to make certain that residents were provided appropriate treatment and care for one of three residents (Residents R1).</p> <p>28 Pa. Code 201.18(b)(1)(2)(3) Management.</p> <p>28 Pa. Code 211.10(a)(c.)(d) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 to prevent accidents for two of three residents (Resident R1 and R2). Findings include: Review of the facility policy Incidents and Accidents dated 9/22/25, indicated it is the policy of the facility for staff to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. Review of facility policy Activities of Daily Living dated 9/22/25, indicated the facility will, based on the resident's comprehensive assessment and consistent with the residents' needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following ADLs: bathing, dressing, grooming and oral care; transfer and ambulation, toileting, eating to include meals and snacks; and using speech, language or other functional communication systems. Review of admission record indicated Resident R1 was admitted to the facility 6/9/25. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/7/25, indicated the diagnoses of hypertension (the force of blood against the artery walls is too high), stroke (damage to the brain from an interruption of blood supply), and hemiplegia (paralysis of one side of the body). Section GG indicated resident was dependent for hygiene and required Substantial/maximal assistance for rolling left to right. Review of Resident R1's physician order from 12/10/24, indicated bed mobility as assist of two staff. Review of Resident R1's current care plan indicated resident has an activities of daily living (ADL) self-care performance deficit. Goal of resident will maintain current level of function in all ADL tasks through review date. Bed mobility assistance of two staff. Transfer with mechanical lift and assistance of two staff. Review of facility provided documentation dated 9/3/25, at 3:30 a.m. indicated Nurse Aide (NA) Employee E1 was making rounds raised Resident R1's bed to begin changing the sheets due to being soiled, NA stepped away from bedside to go get clean sheets. NA heard a loud noise and upon re-entry to the room, noticed the resident was on the floor. Found on floor lying on the left side of the bed. A minor skin tear was noted to the right forearm. Assisted back to bed with Hoyer lift. Further review of facility provided documentation indicated NA Employee E1 did not follow plan of care that included Resident R1 as assist of two staff, and bed to be in low position at all times. NA left the bed in the high position and left the room. Did not have two staff for assist. Review of NA Employee E1's witness statement indicated changing Resident R1, noted bowel movement on the bed pad, went to retrieve linens and found resident on the floor. Interview on 9/30/25, at 2:00 p.m. the Director of Nursing confirmed NA Employee E1 failed to make certain each resident received adequate supervision and assistance to prevent accidents for Resident R1. Review of the admission record indicated Resident R2 admitted to the facility on [DATE]. Review of Resident R2's MDS dated [DATE], indicated the diagnoses of hypertension, renal insufficiency (a condition in which the kidneys lose the ability to remove waste and balance fluids), and heart failure (heart doesn't pump blood as well as it should). Section GG indicated resident was dependent for chair/bed-to-chair transfers. Review of Resident R2's physician orders on 9/3/25, indicated transfers with walker and assist of two. Hoyer lift as needed. Review of Resident R2's care plan indicated transfers with walker and assist of two. Hoyer lift as needed. Review of facility provided documentation dated 9/4/25, indicated NA was transferring Resident R2 from the wheelchair to bed with assistance of walker and resident began to lose balance and the NA lowered resident to the floor. No injuries noted. Interview on 9/30/25, at 2:00 p.m. the Director of Nursing confirmed that the facility failed to make certain each resident received adequate supervision and assistance to prevent accidents for Resident R2, and that the NA only used assistance of one staff, not two as ordered. 28 Pa. Code 211.10(c)(d) Resident Care Policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing Services 28 Pa. Code: 201.18(b)(1) Management.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for five of six residents (Residents R2, R3, R4, R5, and R6). Findings include: Review of facility policy Nebulizer Therapy dated 9/22/25, indicated care of equipment includes clean after each use, disassemble parts after every treatment, rinse the nebulizer (a machine used to deliver aerosolized medications) cup and mouthpiece with sterile or distilled water, and once completely dry, store the nebulizer cup and the mouthpiece in a Ziplock bag. Change nebulizer tubing every seventy-two hours or per facility policy. Review of the facility policy Oxygen Concentrator dated 9/22/25, indicated change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. Change humidifier bottle when empty, every seventy-two hours, or as recommended by the manufacturer. The main body cabinet should be dusted when needed and can be wiped clean with damp cloth and mild household cleaner if necessary. Review of the facility policy CPAP/BiPAP Cleaning dated 9/22/25, indicated clean mask frame daily after use with CPAP cleaning wipe or soap and water. Dry well. Cover with plastic bag or completely enclosed in machine storage when not in use. Review of the admission record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS dated [DATE], indicated the diagnoses of hypertension, renal insufficiency (a condition in which the kidneys lose the ability to remove waste and balance fluids), and heart failure (heart doesn't pump blood as well as it should). Observation on 9/30/25, at 8:48 a.m. of Resident R2's room indicated a nebulizer on the stand, not dated or stored in a bag as required and a CPAP mask not stored in a bag as required. Interview with the Director of Nursing on 9/30/25, at 2:00 p.m. confirmed the nebulizer on the stand, was not dated or stored in a bag as required and a CPAP mask not stored in a bag as required. Review of the admission record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS dated [DATE], indicated the diagnoses of hypertension, diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and repeated falls. Observation on 9/30/25, at 8:52 a.m. of Resident R3's room indicated a nebulizer on the stand, not dated or stored in a bag as required and oxygen tubing dated 9/19/25, past the due date for changing. Interview on 9/30/25, at 8:53 a.m. Licensed Practical Nurse (LPN) Employee E2 confirmed the nebulizer on the stand, was not dated or stored in a bag as required and oxygen tubing dated 9/19/25, was past the due date for changing. Review of the admission record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's MDS dated [DATE], indicated the diagnoses of chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe), diabetes, and high blood pressure. Observation on 9/30/25, at 8:48 a.m. of Resident R4's room indicated a CPAP mask not stored in a bag as required on the nightstand and the back of the oxygen concentrator covered in dust at the filter area. Interview with the Director of Nursing on 9/30/25, at 2:00 p.m. confirmed the CPAP mask not stored in a bag as required and that the concentrator was covered in dust at the filter area. Review of the admission record indicated Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's MDS dated [DATE], indicated the diagnoses of high blood pressure, heart failure, and hyperlipidemia (increased fats in blood). Observation on 9/30/25, at 9:00 a.m. Resident R5 was in bed with oxygen in place. The tubing was not dated, and the humidifier bottle was completely empty. Nebulizer was noted at the bedside table not stored in a bag as required or dated. Interview with the Director of Nursing on 9/30/25, at 2:00 p.m. confirmed R5's tubing was not dated, the humidifier bottle was completely empty, and the nebulizer at the bedside table was not stored in a bag as required or dated. Review of the admission record indicated Resident R6 admitted to the facility on [DATE]. Review of Resident R6's MDS dated [DATE], indicated the diagnoses of high blood pressure, heart failure, and renal insufficiency. Observation on 9/30/25, at 10:48 a.m. of Resident R6 was noted by the nursing station utilizing portable oxygen tank. The oxygen tubing failed to have a date. Interview on 9/30/25, at 10:50 a.m. the Assistant Director of Nursing confirmed the tubing failed to have a date on it. Interview on 9/30/25, at 3:00 p.m. the Director of Nursing confirmed the facility failed to provide appropriate respiratory care for five of six residents (Residents R2, R3, R4, R5, and R6). 28 Pa. Code: 211.8(e) Use of restraints. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on facility policy, clinical record review, facility documents, observation, and staff interview, it was determined that the facility failed to ensure proper hand hygiene for enhanced barrier precautions (EBP) in eight of eight resident rooms with EBP signage on the doors (Rooms 104, 108, 202, 216, 220, 221, 222, and 223). Findings include: Review of the facility policy Enhanced Barrier Precautions dated 9/22/25, indicated implementation of EBP: make gowns and gloves available immediately near or outside of the resident's room. Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room). During an interview and tour on 9/30/25, at 8:48 a.m. with Licensed Practical Nurse (LPN) Employee E2 indicated we've been bringing in our own soap and paper towels. Resident bathrooms in rooms 104, 105, 108, 110, 112, and 118, were confirmed to not have soap in the dispenser or any paper towels in the dispenser. During an interview on 9/30/25, at 8:53 a.m. Nurse Aide (NA) Employee E3 indicated staff do not have anything to wash their hands with or dry their hands with. Staff have been bringing in their own soap and using the resident's dry wipes to dry their hands. During a tour on 9/30/25, from 8:48 a.m. through 9:30 a.m. of the first and second floors, it was noted that the hand sanitizers mounted on the wall were all empty. Interview on 9/30/25, at 9:30 a.m. Environmental Manager Employee E4 indicated there is hand sanitizer at the nursing desks on first and second floors and confirmed that each staff and resident did not have readily accessible hand sanitizer for proper hand hygiene during daily duties and resident care and that the paper towels were due to be delivered today for the empty paper towel dispensers. Interview on 9/30/25, at 2:00 p.m. the Director of Nursing confirmed that the facility failed to ensure proper hand hygiene for enhanced barrier precautions (EBP) in eight of eight resident rooms with EBP signage on the doors (Rooms 104, 108, 202, 216, 220, 221, 222, and 223). 28 Pa. code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 28 Pa. Code: 211.10(a)(d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing services.</p>		