

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 01/22/2026
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, resident interviews, and staff interviews, it was determined that the facility failed to accommodate the needs for four of five residents (Residents R1, R13, R14, and R18). Findings include: Review of facility policy Accommodation of Needs 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 needs and preferences of a resident. Based on individual needs and preferences, the facility will assist the residents in maintaining and achieving independent functioning, dignity, and well-being to the extent possible. Upon entrance to the facility on 1/14/26, at 9:00 a.m. the elevator on the Main floor was not functional and had a sign that stated, Do not use. During an interview on 1/14/26, at 9:45 Maintenance Director Employee E12 stated, If a resident is on the second floor they would need to stay on the second floor. Our only elevator has been broken since 1/6/26, and the repair company will not call me back. Review of the clinical record indicated 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 1/3/26, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and depression. During an observation on 1/14/26, at 11:35 a.m. Resident R1 was observed lying in bed awake. During an interview on 1/14/26, at 11:36 a.m. Resident R1 stated, I feel confined because the elevator doesn't work. I can't get off this floor. I told my friend, so she came to visit me. I like to go downstairs. Review of the clinical record indicated Resident R13 was admitted to the facility on [DATE]. Review of Resident R13's MDS dated [DATE], indicated diagnoses of depression, cerebral palsy (group of disorders that affect a person's ability to move and maintain balance and posture), and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain). During an observation on 1/14/26, at 11:40 a.m. Resident R13 was observed lying in bed awake. During an interview on 1/14/26, at 11:41 a.m. Resident R13 stated, I haven't been on the first floor recently. The elevator doesn't work. I like to go down to the vending machines and visit a friend; his room is down there. Review of the clinical record indicated Resident R14 was admitted to the facility on [DATE]. Review of Resident R14's MDS dated [DATE], indicated diagnoses of depression, high blood pressure, and diabetes. During an observation on 1/14/26, at 11:44 a.m. Resident R14 was observed sitting in a wheelchair at bedside. During an interview on 1/14/26, at 11:45 a.m. Resident R14 stated, The elevator is not working. I like to go down to the community room on the first floor. I can get two free cups of coffee at 10:00 a.m. every day. They don't have coffee on my floor. Review of the clinical record indicated Resident R18 was admitted to the facility on [DATE]. Review of Resident R18's MDS dated [DATE], indicated diagnoses of high blood pressure, muscle weakness, and fracture. During an observation on 1/14/26, at 11:48 a.m. Resident R18 was observed lying in bed awake. During an interview on 1/14/26, at 11:50 a.m. Resident R18 stated, If the elevator worked, I would go downstairs. The elevator isn't working. They have a big TV, I</p> <p>(continued on next page)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395666
		If continuation sheet Page 1 of 30

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	like to play games, get snacks from the vending machines, and I like to mingle with others. During an interview on 1/14/26, at 1:10 p.m. the Nursing Home Administrator 1 confirmed that the facility failed to accommodate the needs for four of five residents (Residents R1, R13, R14, and R18). 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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, staff interviews, resident interviews, and observations it was determined that the facility failed to ensure that residents were free from neglect and failed to timely and effectively manage 12 allegations of resident neglect, which created an Immediate Jeopardy situation for 12 of 12 residents (Resident R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, and R12). Findings include: Review of facility Abuse, Neglect, Mistreatment policy dated 9/22/25, indicated the facility prohibits the mistreatment, neglect, and abuse of residents and misappropriation of resident property by anyone including staff, family, friends, etc. The facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse, neglect, mistreatment, and misappropriation of property. The facility must provide a safe resident environment and protect residents from abuse and neglect. The administrator and Director of Nursing are responsible for investigating and reporting. Upon receiving an incident or abuse, neglect, misappropriation of resident property, an investigation will be conducted. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress. During a tour of the second-floor nursing floor on 1/14/26, at 11:55 a.m. Nurse Aide (NA) Employee E1 stated, There are only two NA's on the floor, the third one didn't show up. We have told management. The Administrator, the Director of Nursing (DON), and the supervisor. Those people down that hall haven't been touched since probably overnight shift. When State Agency (SA) clarified what hallway, the NA Employee E1 pointed to the [NAME] Hall, Third Assignment (Resident rooms 209-A through 217-B). During a review of facility provided documentation, labeled Daily Assignment Sheets, on 1/14/26, at 12:05 p.m. revealed that the assignment labeled West, Rooms 209-A through 217-B were assigned to a NA who failed to show up for scheduled work shift and the assignment was not reassigned to another staff member. Review of residents in section 209-A through 217-B revealed that twelve residents reside in that section and need assistance with Activities of Daily Living. During an interview on 1/14/26, at 12:11 p.m. Licensed Practical Nurse (LPN) Employee E2 stated, When I found out we didn't have a third NA, I talked to the supervisor. She said the nurses will need to help the NA's. I told her I can't help today; I can barely walk. No care has been done since overnight shift. No baths, no showers, no incontinence care, no repositioning, residents have not gotten out of bed. During an interview on 1/14/26, at 12:14 p.m. Registered Nurse Employee E6 stated, I offered to help them but LPN Employee E2 said she isn't helping because that's why she became a nurse. She doesn't want to help me. I'm just a cart nurse today. During an interview on 1/14/26, at 12:26 p.m. the SA met with the Nursing Home Administrator (NHA)1 and DON1 and reported the observations and interviews from the second floor. The SA informed and reported 12 allegations of neglect to the NHA1 and DON1 at this time. Observations of residents on January 14, 2026, at 12:50 p.m. revealed all residents in section 209-A through 217-B were in their bed with a disheveled appearance. Review of the clinical record indicated 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 1/3/26, indicated diagnoses of high blood pressure, depression, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). During an observation on 1/14/26, at 12:59 p.m. Resident R1 was lying in bed. During an interview on 1/14/26, at 1:00 p.m. Resident R1 stated, The nurse came in this morning for medication. Nobody else has been in to check on me or to see if I need anything. I wanted to talk to the nurse practitioner and had to go find someone to ask to see her. I wish someone would have come into my room. Review of the clinical record indicated Resident R7 was admitted</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>interview on 1/14/26, at 1:29 p.m. Resident R5 stated, I'm still in my night gown. No one has been into help me. I need help. I can't get up myself. I have had diarrhea and I have been soiled since early this morning. I kept ringing my call bell and someone came in and said they didn't have an NA. No one else has been in. My bottom gets a little raw and I make sure they put cream on, but nobody's been in today. Review of the clinical record indicated Resident R11 was admitted to the facility on [DATE]. Review of Resident R11's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes, and paraplegia (loss of motor and sensory function in the lower half of the body). During an observation on 1/14/26, at 1:35 p.m. Resident R11 was lying in bed with a night gown on. During an interview on 1/14/26, at 1:36 p.m. Resident R11 stated, No one has cleaned me up today. My brief hasn't been changed today. I need changed. It's been soiled all day. I usually get cream put on but I haven't gotten it today. Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's MDS dated [DATE], indicated diagnoses of high blood pressure, peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and cerebral infarction. During an observation on 1/14/26, at 1:37 p.m. Resident R6 was lying in bed with a night gown on. During an interview on 1/14/26, at 1:38 p.m. Resident R6 stated, I haven't been cleaned up today. Review of the clinical record indicated Resident R12 was admitted to the facility on [DATE]. Review of Resident R12's MDS dated [DATE], indicated diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), muscle weakness, and depression. During an observation on 1/14/26, at 1:41 p.m. Resident R12 was resting in bed with eyes closed, with a night gown on. During an observation on 1/14/26, at 1:42 p.m. RN Employee E6, LPN Employee E2, and NA Employee E1 were at the nurse's station talking amongst themselves. During an interview on 1/14/26, at 1:43 p.m. LPN Employee E2 stated I don't have a problem pitching in, but it seems like we are pushed to the side up here. No one from downstairs came up to help us. I just can't do care. I'm not good with care now. The whole section hasn't had a NA all day. No care has been provided yet. Incontinence care has not been done. Some people have not been repositioned. I feel very bad. When asked what could happen when care is not provided, LPN Employee E2 replied, Skin breakdown can happen, they feel like no one cares. I know some want to get up but they haven't been gotten up. During an interview on 1/14/26, at 1:49 p.m. RN Employee E6 stated, I am the nurse on the unit. I'm not the supervisor. I function as a nurse on the cart. Even though I am in a different hall, there is no reason to let residents go. I offered to help LPN Employee E2 but she said she doesn't want to. When asked what could happen when care is not provided, RN Employee E6 replied, we need to help each other. Nothing has been done today. Lots of things could happen such as ulcers. They are being neglected. There could be a situation in the room and wouldn't know it. They might not be breathing and we wouldn't know. During an interview on 1/14/26, at 1:55 p.m. NA Employee E1 stated, That section didn't have a NA assigned after someone didn't show up for work. No morning care was done, no baths or showers, no one has been gotten out of bed, no teeth brushed, and no incontinent care has been done. When asked what could happen when care is not provided, NA Employee E1 replied, they can break down. Skin is at risk. Pressure sores can happen. During an interview on 1/14/26, at 1:58 p.m. NA Employee E4 stated, Residents in Section 209-A through 217-B were not taken care of today, that includes bathing, showering, dressing, getting out of bed, teeth brushing, changing. When asked what could happen when care is not provided, NA Employee E4 replied, Its neglect. They can get bed sores and start to lose mobility. During an interview on 1/14/26, at 2:05 p.m. RN Employee E3 stated, One NA did not show up on the second floor. I was made aware and started making calls. I let the DON1 and scheduler know. I informed nurses that we were down a NA, and they</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>would have to pitch in and assist today. The two NA's did not venture to help and split the floor into two sections, instead of three. Residents did not get care. I have a problem with that. Our job is to take care of the residents and not separate. It's not fair. It's wrong. During an interview on 1/14/26, at 2:15 p.m. the SA met with the NHA1 and DON1 for the second time and reported the observations and interviews from the second floor. The SA reported that residents in section 209-A through 217-B, which included 12 residents, still failed to have any care provided and neglect was reported almost two hours prior. On 1/14/26, at 7:00 p.m. the NHA1 and DON1 were notified that Immediate Jeopardy was called due to resident neglect of 12 residents that was reported twice on 1/14/26, for Residents R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, and R12 at 12:26 p.m. and again at 2:15 p.m. The NHA1 and DON1 were provided with the Immediate Jeopardy template, and a corrective action plan was requested. On 1/15/26, at 12:57 a.m. an immediate action plan was received and accepted which included the following interventions: All residents will be assessed and a full body head to toe skin check will be performed for any indications of skin concerns. Any identified concerns will be immediately addressed; findings will be documented in resident's medical records and attending physician and responsible parties will be notified of adverse findings. Facility Medical Director, attending physician for resident (if different from Medical Director), and responsible party for resident will be notified of the neglect that was identified on 1/14/26, as well as any potential indications of skin concerns or ill effects secondary to alleged neglect. Report will be called into Adult Protective Services. Department of Health event report will be completed and applicable PB22's. Resident care plans will be updated as applicable to reflect changes as identified. Facility NHA, DON, Scheduler and/or Designee will review the current schedule and ensure adequate staff are scheduled to ensure that care is provided to avoid neglect. All current nursing staff, including agency, will be educated on facility policy for abuse and neglect by 3:00 p.m. January 15, 2026, and sign the education prior to their next working shift. DON/Designee will conduct audits for resident care needs five times a week for four weeks, then weekly for four weeks to ensure that no abuse or neglect is identified. Results of the audit will be reported to Ad Hoc Quality Assurance Performance Improvement (QAPI) committee on January 15, 2026. During a SA review of the immediate action plan on 1/20/26, at 4:00 p.m. revealed the following: On 1/16/26, all residents were assessed and skin evaluations were completed and documented in residents' medical records. No negative outcomes were identified. On 1/16/26, responsible parties were made aware of the neglect that was identified on 1/14/26. On 1/16/26, Department of Health event report was completed by NHA1. On 1/17/26, Medical Director was made aware of the neglect that was identified on 1/14/26. On 1/18/26, Adult Protective Service were notified of 12 allegations of neglect that were identified on 1/14/26. On 1/18/26, the DON, scheduler, designee reviewed current schedule, identified areas that need more staff to meet the needs of the residents, and reviewed assignment sheets to avoid neglect. On 1/18/26, DON/designee started audits to ensure that no neglect was identified. On 1/18/26, Ad Hoc QAPI meeting was held and signatures provided that attended meeting. On 1/19/26, resident care plans were updated to reflect resident neglect, outcomes, and interventions were completed for the 12 residents that were neglected. On 1/19/26, current nursing staff, including agency, educated on abuse and neglect policy. Staff will sign the education prior to their next working shift if education isn't completed in person. Staff education was verified on 1/20/26, with dated sign-in sheets and review of all current staff and agency staff utilized in the facility having signed and/or educated over the phone as indicated. During in-person and phone interviews completed on 1/20/26, from 11:00 a.m. until 3:30 p.m. 20/44 nursing staff confirmed that they were educated in person, and 1/44 staff were educated via phone. Staff were educated on the facilities, abuse and neglect</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on reviews of facility policy, employees files, facility documentation, and staff interviews, it was determined that the facility failed to ensure annual abuse and neglect prevention training was completed for five of seven staff members (Nurse Aide (NA) Employee E1, Registered Nurse (RN) Employee E3, NA Employee E4, RN Employee E6, and the Director of Nursing (DON) identified in an incident of reported neglect. The facility also failed to provide annual abuse and neglect training for 88 of 90 current Facility Employees for 12 of 12 months (January through [DATE]). The facility also failed to screen employees for a potential history of abuse by completing pre-employment criminal background checks for one of seven employees (Licensed Practical Nurse (LPN) Employee E2). The facility also failed to verify current, valid license from licensing and registration boards to verify any disciplinary actions prior to employment for five of seven employees (NA Employee E1, RN Employee E3, NA Employee E4, RN Employee E6, and the DON) resulting in an Immediate Jeopardy for 66 of 66 residents. The facility also failed to conduct a Federal Bureau of Investigation (FBI) background check as required for one of two out-of-state employees (Employee E14). Findings include: Review of facility policy Abuse, Neglect, & Mistreatment, reviewed [DATE], indicated that the facility prohibits the mistreatment, neglect, and abuse of residents. Abuse, Neglect and Misappropriation of Resident Funds and Property education is completed upon hire and at least annually for all employees. Implementation and ongoing monitoring consist of screening, training, prevention, identification, protection, investigation, and reporting. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect of goods and services may occur when staff are aware, or should be aware, of resident's care needs, based on assessment and care planning, but are unable to meet identified needs due to other circumstances, such as lack of training to perform an intervention, lack of sufficient staffing to be able to provide the services, lack of supplies, or staff lack knowledge of the needs of a resident. All potential employees are screened for history of abuse, neglect, or mistreating residents during the hiring process. Screening will consist of but limited to inquiries into State licensing authorities and or State nurse aide registry, criminal background checks. During an interview on [DATE], at 11:55 a.m. NA Employee E1 stated that there was an assignment of 12 residents on the Second Floor who did not receive any morning care on [DATE], as there was no one assigned to rooms 209-A- 217B. During an interview on [DATE], at 12:26 p.m. the Nursing Home Administrator (NHA), and DON were informed by State Agency (SA) that 12 residents on the Second Floor had not yet received morning care as there was no one assigned to do so. During an additional interview on [DATE], at 2:18 p.m. the NHA and DON were made aware by SA that the same 12 residents still have not received any morning care. During an interview on [DATE], at 1:52 a.m. Human Resources Director Employee E5 stated that annual education is completed January through December, but that no education was completed January through [DATE] which was when she started working at the facility. During an interview on [DATE], at 12:02 p.m. the DON stated that the facility no longer has an account to run background checks on new employees. During an interview on [DATE], at 12:02 p.m. the NHA confirmed that the facility identified seven alleged perpetrators (APs) of neglect for the above incident that occurred on [DATE], which were confirmed to be NA Employee E1, LPN Employee E2, RN Employee E3, NA Employee E4, RN Employee E6, DON, and NHA. During an interview on [DATE], at 12:37 p.m. the Human Resources Director Employee E5 brought in folders that contained the education that was completed in 2025, and confirmed that this was a complete list. The topics included Workplace Safety, Double Briefing, Sexual Harassment, Dementia, Corporate Compliance, and Disaster Drill. Abuse and Neglect education</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>was not on the list of facility provided education for 2025. Review of Employee Files for the seven above employees listed as APs indicated the following: NA Employee E1 who had a start date at the facility of [DATE], had no documentation that education on Abuse and Neglect was received for the year of 2025, and had a NA license on file that expired [DATE]. LPN Employee E2 who had a start date at the facility of [DATE], had no documentation that a pre-employment background check had been completed prior to the start date of employment. RN Employee E3 who had a start date at the facility of [DATE], had no documentation that education on Abuse and Neglect was received for 2025, and no RN license on file. NA Employee E4 who had a start date at the facility of [DATE], had no documentation that education on Abuse and Neglect was received for 2025, and had a NA license on file that expired [DATE]. RN Employee E6 who had a start date at the facility of [DATE], had no documentation that Abuse and Neglect education was received for 2025, and had a RN license on file that expired 10-31-24. DON who had a start date at the facility on [DATE], had no documentation that Abuse and Neglect education was received for 2025, and had a RN license on file that expired on [DATE]. During an interview on [DATE], at 3:41 p.m. the NHA confirmed that there was no annual abuse training for five of seven staff members NA Employee E1, RN Employee E3, NA Employee E4, RN Employee E6, and the DON identified in an incident of reported neglect, no annual Abuse and Neglect training for 90 of 90 current Facility staff for 12 of 12 months (January through [DATE]), had expired licenses, or no license on file for five of seven employees (NA Employee E1, RN Employee E3, NA Employee E4, RN Employee E6, and DON) and failed to complete pre-employment background checks for one of seven employees (LPN Employee E2). On [DATE], at 3:49 p.m. the Nursing Home Administrator was made aware that an Immediate Jeopardy situation existed and the Immediate Jeopardy template was provided to facility administration. On [DATE], at 4:53 p.m. an acceptable Corrective Action Plan was received which included the following interventions: Facility has reviewed current policy on abuse and neglect. All current facility staff including agency will receive training on current facility policy for abuse/neglect by 4:00 p.m.XXX[DATE]. Those who do not complete education will not be permitted to work until education is completed.All current facility employee files, including agency, will be reviewed by 4:00 p.m. on [DATE] to ensure that they have education on facility policy for abuse and neglect and a current and active license on file as well as a background check present in their file. Missing items that are identified in audit will be immediately corrected.Facility will audit all new hire and all new agency staff files to ensure that files contain evidence of abuse education and current, active license as well as background check.Results of the audit will be reported to Ad Hoc Quality Assurance Performance Improvement Committee on [DATE]. During an interview on [DATE], at 11:24 a.m. the NHA stated I don't even know the process of checking expired license. Note that on [DATE] at 3:00 p.m. none of the above information in the Corrective Action Plan was received. Review of facility documents on [DATE], indicated that 99 of 107 Facility and Agency Employees received education from the facility on Abuse and Neglect, and Mistreatment. Eleven of these employees received education via telephone as they were not currently working in the building. During staff interviews conducted on [DATE], at 12:45 p.m. through [DATE], at 2:51 p.m. 37 staff members confirmed they received education on abuse and neglect. Three of these employees had confirmed receiving education via telephone. During an interview on [DATE] at 1:16 p.m. NA Employee E17 stated that she received education on abuse and neglect but added It's been a long time since I received it before this week. During an interview on [DATE], at 1:18 p.m. NA Employee E18 confirmed that she received education on abuse and neglect at the facility but added I get it all the time at my other job, but not here. Review of facility audits on [DATE], at 3:00 p.m. revealed that 17 out of 17 Agency Employees had completed pre-employment background checks</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>and active, valid licenses on file. Review of facility audits on [DATE], at 3:01 p.m. revealed that 64 out of 66 licensed Facility Employees had an active, valid license. During an interview on [DATE], at 3:05 p.m. NHA 3 stated that two employees were sent home due to an inactive license. These employees were identified as NA Employee E15 whose license had expired on [DATE], and NA Employee E16 whose license had expired on [DATE]. NA Employee E15's last day working at the facility was [DATE], and NA Employee E16's last day working at the facility was [DATE]. Review of facility audits on [DATE], at 5:24 p.m. revealed that 64 of 90 Facility Employees had background checks completed prior to hire, and present in employee file. 26 employees had no pre-employment background check in employee file. Facility completed background checks on these 26 employees on [DATE], which brought facility to 100% compliance. Review of Scheduler Employee E14's personnel file on [DATE], revealed that she lives out of state, and although she had a state background check prior to employment, no documentation was present in the file that the facility conducted an FBI background check as required for out-of-state employees prior to employment. Employee E14 was sent home pending the FBI background check. The Immediate Jeopardy was lifted on [DATE], at 6:03 p.m. when the action plan implementation was verified. During an interview on [DATE], at 9:06 a.m. NHA 3 confirmed that the facility failed to conduct an FBI background check for one of two out-of-state employees (Scheduler Employee E14) prior to employment, and that Employee E14 remained out of the facility as she was actively working on getting the FBI background check completed. During an interview on [DATE], at approximately 2:00 p.m. NHA 2 confirmed that the facility failed to ensure annual abuse and neglect prevention training was completed for five of seven staff members identified in an incident of reported neglect, and failed to provide documentation of annual abuse and neglect training for 90 of 90 current facility employees for 12 of 12 months (January through [DATE]), and failed to screen potential employees for a history of abuse by completing pre-employment criminal background checks for two of seven employees, and failed to verify current, valid license from licensing and registration boards to verify any disciplinary actions prior to employment for five of seven employees resulting in an Immediate Jeopardy for 66 of 66 residents. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.19 (3)(7) Personnel policies and procedures.</p>		

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<p>F 0725</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident and staff interviews, and observations, it was determined that the facility failed to have sufficient nursing staff to provide nursing related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, which created an Immediate Jeopardy situation for 12 of 12 residents residing on one of two halls (West Hall) for Residents R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, and R12). Findings Include: Review of the facility policy Resident Rights dated 9/22/25, indicated all residents will be treated with respect, and dignity. Residents have the right to reside and receive services in the facility. The residents have the right to a safe, clean, comfortable and homelike environment including but not limited to receiving treatment and support for daily living. Review of the facility Facility Assessment Tool dated 9/22/25, indicated specific staffing needs, including nights, holidays, and weekends, ratios, knowledge and skills, maximizing direct care staff recruitment and retention to meet the needs of the residents. The facility implements a proactive and systematic approach involving regular review of staffing and other potential disruptions. The facility cross trains staff members for work within the facility, and on-call staff are available, and partnerships with staffing agencies. During a tour of the second-floor nursing floor on 1/14/26, at 11:55 a.m. Nurse Aide (NA) Employee E1 stated, There are only two NA's on the floor, the third one didn't show up. We have told management. The administrator, the Director of Nursing (DON), and the supervisor. Those people down that hall haven't been touched since probably overnight shift. When State Agency (SA) clarified what hallway, the NA Employee E1 pointed to the [NAME] Hall, Third Assignment (Resident rooms 209-A through 217-B). During a review of facility provided documentation, labeled Daily Assignment Sheets, on 1/14/26, at 12:05 p.m. revealed that the assignment labeled West, Rooms 209-A through 217-B were assigned to a NA who failed to show up for scheduled work shift and the assignment was not reassigned to another staff member. Review of residents in section 209-A through 217-B revealed that twelve residents reside in that section and need assistance with Activities of Daily Living. During an interview on 1/14/26, at 12:11 p.m. Licensed Practical Nurse (LPN) Employee E2 stated, When I found out we didn't have a third NA, I talked to the supervisor. She said the nurses will need to help the NA's. I told her I can't help today; I can barely walk. No care has been done since overnight shift. No baths, no showers, no incontinence care, no repositioning, residents have not gotten out of bed. During an interview on 1/14/26, at 12:14 p.m. Registered Nurse Employee E6 stated, I offered to help them but LPN Employee E2 said she isn't helping because that's why she became a nurse. She doesn't want to help me. I'm just a cart nurse today. During an interview on 1/14/26, at 12:26 p.m. the SA met with the Nursing Home Administrator (NHA)1 and DON1 and reported the observations and interviews from the second floor. The SA informed and reported 12 allegations of neglect to the NHA1 and DON1 at this time. Observations of residents on January 14, 2026, at 12:50 p.m. revealed all residents in section 209-A through 217-B were in their bed with a disheveled appearance. Review of the clinical record indicated 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 1/3/26, indicated diagnoses of high blood pressure, depression, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). During an observation on 1/14/26, at 12:59 p.m. Resident R1 was lying in bed. During an interview on 1/14/26, at 1:00 p.m. Resident R1 stated, The nurse came in this morning for medication. Nobody else has been in to check on me or to see if I need anything. I wanted to talk to the nurse practitioner and had to go find someone to ask to see her. I wish someone would have come into my room. Review of</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>the clinical record indicated Resident R7 was admitted to the facility on [DATE].Review of Resident R7's MDS dated [DATE], indicated diagnoses of diabetes, depression, and asthma (condition where the airways narrow and swell).During an observation on 1/14/26, at 1:06 p.m. Resident R7 was lying in bed with a night gown on.During an interview on 1/14/26, at 1:07 p.m. Resident R7 stated, The NA just got me towels to get cleaned up. Nobody has been in today to check on me.Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE].Review of Resident R2's MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety, and gastroesophageal reflux disease (GERD) (a condition where stomach acid frequently flows back into the throat).During an observation on 1/14/26, at 1:08 p.m. Resident R2 was lying in bed with a night gown on.During an interview on 1/14/26, at 1:09 p.m. Resident R2 stated, I need to get cleaned up. So far, I haven't gotten cleaned up. Nobody has been in the check on me.Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE].Review of Resident R3's MDS dated [DATE], indicated diagnoses of diabetes, hemiplegia (paralysis on one side of the body), and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain).During an observation on 1/14/26, at 1:12 p.m. Resident R3 was lying in bed with a nightgown on.During an interview on 1/14/26, at 1:13 p.m. Resident R3 stated, Nobody has been in to clean me up. No one has changed by brief since last night. I asked about getting up when someone brought my lunch tray in, but they said no one came in to work so they couldn't get me up. I would like to get up and move around. My bottom is somewhat sore. I haven't had any cream on because I haven't been changed.Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE].Review of Resident R8's MDS dated [DATE], indicated diagnoses of high blood pressure, depression, and arthritis (inflammation of one or more joints, causing pain and stiffness).During an observation on 1/14/26, at 1:18 p.m. Resident R8 was resting her eyes closed in bed with a night gown on.Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE].Review of Resident R4's MDS dated [DATE], indicated diagnoses of cerebral infarction, depression, and Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking).During an observation on 1/14/26, at 1:19 p.m. Resident R4 was lying in bed with a night gown on.During an interview on 1/14/26, at 1:20 p.m. Resident R4 stated, No one has been into clean me up today. My brief hasn't changed and it needs to be changed. Nobody has been in to check on me.Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE].Review of Resident R9's MDS dated [DATE], indicated diagnoses of high blood pressure, depression, and heart failure (a progressive heart disease that affects pumping action of the heart muscles).During an observation on 1/14/26, at 1:21 p.m. Resident R9 was lying in bed with a night gown on.During an interview on 1/14/26, at 1:22 p.m. Resident R9 stated, Nobody has been in the check on me today. I need towels, and wash towels to wash up but nobody has been in. I wasn't able to get cleaned up today.Review of the clinical record indicated Resident R10 was admitted to the facility on [DATE]. Review of Resident R10's MDS dated [DATE], indicated diagnoses of heart failure, coronary artery disease (damage or disease in the heart's major blood vessels), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life).During an observation on 1/14/26, at 1:25 p.m. Resident R10 was sitting at the side of bed with a night gown on.During an interview on 1/14/26, at 1:26 p.m. Resident R10 stated, I haven't gotten up yet. I haven't gotten cleaned up. It seems like they expect me to do it, but I can't. I had diarrhea yesterday. I need to be cleaned. Nobody has been in to check on me.Review of the clinical record indicated Resident R5 was admitted to the facility on [DATE].Review of Resident R5's MDS dated [DATE], indicated diagnoses of diabetes, difficulty in walking, and osteomyelitis (an infection in the bone).During an observation on 1/14/26, at 1:28 p.m. Resident</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R5 was sitting in bed with a night gown on.During an interview on 1/14/26, at 1:29 p.m. Resident R5 stated, I'm still in my night gown. No one has been into help me. I need help. I can't get up myself. I have had diarrhea and I have been soiled since early this morning. I kept ringing my call bell and someone came in and said they didn't have an NA. No one else was in. My bottom gets a little raw and I make sure they put cream on, but nobody's been in today.Review of the clinical record indicated Resident R11 was admitted to the facility on [DATE].Review of Resident R11's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes, and paraplegia (loss of motor and sensory function in the lower half of the body).During an observation on 1/14/26, at 1:35 p.m. Resident R11 was lying in bed with a night gown on.During an interview on 1/14/26, at 1:36 p.m. Resident R11 stated, No one has cleaned me up today. My brief hasn't been changed today. It needs changed. It's been soiled all day. I usually get cream put on but I haven't gotten it today.Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE].Review of Resident R6's MDS dated [DATE], indicated diagnoses of high blood pressure, peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and cerebral infarction.During an observation on 1/14/26, at 1:37 p.m. Resident R6 was lying in bed with a night gown on.During an interview on 1/14/26, at 1:38 p.m. Resident R6 stated, I haven't been cleaned up today.Review of the clinical record indicated Resident R12 was admitted to the facility on [DATE].Review of Resident R12's MDS dated [DATE], indicated diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), muscle weakness, and depression.During an observation on 1/14/26, at 1:41 p.m. Resident R12 was resting in bed with eyes closed, with a night gown on.During an observation on 1/14/26, at 1:42 p.m. RN Employee E6, LPN Employee E2, and NA Employee E1 were at the nurse's station talking amongst themselves.During an interview on 1/14/26, at 1:43 p.m. LPN Employee E2 stated I don't have a problem pitching in, but it seems like we are pushed to the side up here. No one from downstairs came up to help us. I just can't do care. I'm not good with care now. The whole section hasn't had a NA all day. No care has been provided yet. Incontinence care has not been done. Some people have not been repositioned. I feel very bad. When asked what could happen when care is not provided, LPN Employee E2 replied, Skin breakdown can happen, they feel like no one cares. I know some want to get up but they haven't gotten up.During an interview on 1/14/26, at 1:49 p.m. RN Employee E6 stated, I am the nurse on the unit. I'm not the supervisor. I function as a nurse on the cart. Even though I am in a different hall, there is no reason to let residents go. I offered to help LPN Employee E2, but she said she doesn't want to. When asked what could happen when care is not provided, RN Employee E6 replied, we need to help each other. Nothing has been done today. Lots of things could happen such as ulcers, they are being neglected. There could be a situation in the room and wouldn't know it. They might not be breathing and we wouldn't know.During an interview on 1/14/26, at 1:55 p.m. NA Employee E1 stated, That section didn't have a NA assigned after someone didn't show up for work. No morning care was done, no baths or showers, no one has been gotten out of bed, no teeth brushed, and no incontinent care has been done. When asked what could happen when care is not provided, NA Employee E1 replied, they can break down. Skin is at risk. Pressure sores can happen.During an interview on 1/14/26, at 1:58 p.m. NA Employee E4 stated, Residents in Section 209-A through 217-B were not taken care of today, that includes bathing, showering, dressing, getting out of bed, teeth brushing, changing. When asked what could happen when care is not provided, NA Employee E4 replied, Its neglect. They can get bed sores and start to lose mobility.During an interview on 1/14/26, at 2:05 p.m. RN Employee E3 stated, One NA did not show up on the second floor. I was made aware and started making calls. I let the DON1 and scheduler know. I</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>informed nurses that we were down a NA, and they would have to pitch in and assist today. The two NA's did not venture to help and split the floor into two sections, instead of three. Residents did not get care. I have a problem with that. Our job is to take care of the residents and not separate. It's not fair. It's wrong. During an interview on 1/14/26, at 2:15 p.m. the SA met with the NHA1 and DON1 for the second time and reported the observations and interviews from the second floor. The SA reported that residents in section 209-A through 217-B, which included 12 residents, still failed to have any care provided and neglect was reported almost two hours prior. On 1/14/26, at 7:00 p.m. the NHA1 and DON1 were notified that Immediate Jeopardy was called due to the facility failing to have sufficient nursing staff to meet the needs of the residents, for 12 of 12 residents (Residents R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, and R12). The NHA1 and DON1 were provided with the Immediate Jeopardy template, and a corrective action plan was requested. On 1/15/26, at 12:57 a.m. an immediate action plan was received and accepted which included the following interventions: Facility DON, NHA, Scheduler, and Designee will review current staffing sheets for facility to ensure that adequate staff are present in the facility to meet the residents' needs. Facility will prepare and review current emergency staffing policy and procedures to determine appropriate actions in case of emergency staffing needs. Facility will review all agency staffing contracts and/or obtain and request additional agency staffing contracts as a back-up to current existing agency contracts. NHA, DON, Scheduler or Designee will be educated on how to staff the facility to meet the needs of the facility residents by 3:00 p.m. on January 15, 2026. Facility NHA, DON, Scheduler or Designee will review the current schedule to ensure adequate staff are scheduled to ensure adequate care is provided and neglect is avoided. Facility nursing staff, including agency, will be educated on meeting staffing needs for each nursing unit by 3:00 p.m. on January 15, 2026, and sign the education prior to their next working shift. The facility identified a shortage in nurse aides on the night shift on January 14, 2026. The facility immediately re-aligned the nurse aide assignments to ensure that all residents are taken care of. The facility will maintain the projected weekend ratios. The facility will hold admissions for a period of two weeks to ensure that adequate staffing is maintained for the current census. The facility will maintain the following staffing pattern to meet the needs of the residents: First floor- First shift = 2 nurses/4 nurse aides First floor - Second shift = 2 nurses/3 nurse aides First floor- Third shift = 1 nurse/3 nurse aides Second floor - First shift = 2 nurses/3 nurse aides Second floor- Second shift = 2 nurses/3 nurse aides Second floor- Third shift = 1 nurse/ 2 nurse aides One RN Supervisor for each shift Facility DON/Designee will perform audits to ensure that the facility staffing meets the care needs for the residents five times a week for four weeks, then weekly for four weeks to ensure that no abuse or neglect is identified. Results of the audit will be reported to an Ad Hoc Quality Assurance Performance Improvement (QAPI) Committee on January 15, 2026. During a SA review of the immediate action plan on 1/20/26, at 4:30 p.m. revealed the following: On 1/14/26, the facility re-aligned the nurse aide assignment for night shift assignments to ensure that all residents are taken care of. On 1/15/26, the NHA1 confirmed that the facility will not be accepting any new residents for two weeks to ensure that adequate staffing is maintained for the current census. On 1/18/26, the NHA, DON, and scheduler reviewed the current schedule and assignment sheets to identify nursing staff needs to ensure adequate staff are scheduled to provide care and neglect is avoided. The facility will maintain the staffing pattern to meet the needs of the residents as part of the plan of correction. On 1/18/26, the facility reviewed current emergency staffing policy and procedures and updated with additional information. On 1/18/26, through 1/20/26, the facility signed additional agency nursing staff contracts as a back-up to current existing agency contracts. On 1/18/26, the NHA, DON,</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Spring Hill Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2170 Rhine Street Pittsburgh, PA 15212	
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<p>F 0725</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Scheduler and Designee was educated on how to staff the facility to meet the needs of the facility. On 1/18/26, the DON/Designee performed audits to ensure facility staffing meets the care for the residents. On 1/18/26, the facility conducted an Ad Hoc QAPI meeting and provided signatures for attendees. On 1/20/26, the facility nursing staff, including agency nursing staff, was educated on meeting staffing needs for each nursing unit. Staff education was verified with dated sign-in sheets and review of all current staff and agency staff utilized in the facility having signed and/or educated over the phone as indicated. During in-person and phone interviews completed on 1/20/26, from 11:00 a.m. until 3:30 p.m. 20/44 nursing staff confirmed that they were educated in person and 1/44 staff were educated via phone. Staff were educated on that all residents must be assigned to a staff member who is working in facility and if a staff member notices that someone is missing, notify supervisor and assignments will be changed to ensure all residents are cared for. Staff were also educated on the facilities, abuse and neglect policies, definition, the kinds of abuse and were given verbal examples of what abuse and neglect would be considered. Staff were educated on when to report allegations of abuse and neglect. All staff educated in person signed the education sheet. 43/44 nursing staff members were educated. All other staff will be educated prior to their next shift and sign the education sheet. During an interview on 1/20/26, at 2:28 p.m. NA Employee E17 stated, I was educated on abuse and neglect. If there are not enough staff, they will change assignments, so all residents are taken care of. It doesn't matter if I'm assigned to them or not, their needs and care come first. During an interview on 1/20/26, at 2:42 p.m. NA Employee E18 stated, I was educated on staff to residents. Assignments are made to make sure that all residents are cared for. During an interview on 1/20/26, at 2:51 p.m. NA Employee E19 stated, I have been educated on abuse and neglect. If you see a section short, make sure everyone is reassigned to a resident. Verification of the facility's Corrective Action Plan revealed all elements of plan were met. The Immediate Jeopardy was lifted on 1/20/26, at 5:51 p.m. NHA2 was made aware. During an interview on 1/14/26, at 2:15 p.m. the NHA1 and DON1 confirmed that the facility failed to have sufficient nursing staff to provide nursing related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, which created an Immediate Jeopardy situation for 12 of 12 residents residing on one of two halls (West Hall) for Residents R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, and R12). This failure created an immediate jeopardy situation by potentially putting residents at risk of harm or injury. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(1)(4)(5) Nursing services</p>		

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<p>F 0729</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility job descriptions, facility documents, personnel files, and staff interviews, it was determined the facility failed to ensure that staff renewed their nurse aide registration to allow individuals to work as a nurse aide for two of 28 nurse aides (NA) reviewed (NA Employee E15, and E16). Finding include: Review of the facility document Employee Handbook indicated that persons hired as part of the professional staff are required to have and maintain a valid current license or certification. Review of facility audits on [DATE], at 3:01 p.m. revealed that 64 out of 66 licensed Facility Employees had an active, valid license. During an interview on [DATE], at 3:05 p.m. NHA 3 stated that two employees were sent home due to an inactive license. These employees were identified as NA Employee E15 whose license had expired on [DATE], and NA Employee E16 whose license had expired on [DATE]. NA Employee E15's last day working at the facility was [DATE], and NA Employee E16's last day working at the facility was [DATE]. NHA 3 confirmed that the facility failed to ensure that staff renewed their nurse aide registration to allow individuals to work as a nurse aide for two of five nurse aides reviewed. 28 Pa. Code 201.19 (3) Personnel Policies and Procedures.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>Based on review of personnel records and staff interview, it was determined that the facility failed to complete annual performance evaluation at least once every 12 months for two of two nurse aide (NA) personnel records (NA Employee E1, and E4). Findings include: Review of the facility's Employee Handbook indicated that all employees will be subject to a written annual rating and evaluations by the department supervisor based on their anniversary date. Review of NA Employee E1's personnel record indicated a hire date of 10/25/21. Review of NA Employee E1's personnel records revealed that no performance evaluation was conducted between 10/1/24 and 10/1/25. Review of NA Employee E4's personnel record indicated a hire date of 11/23/21. Review of NA Employee E4's personnel records revealed that no performance evaluation was conducted between 11/23/24, and 11/23/25. During an interview on 1/19/26, at 10:56 a.m. Human Resources Director Employee E5 confirmed that the facility failed to complete annual performance evaluation at least every 12 months for NA Employee E1, and E4. 28 Pa Code: 201.14 (b) Responsibility of licensee 28 Pa Code: 201.18 (b)(1)(3) Management</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Based on review of job descriptions, clinical records, observations, and staff interviews, it was determined that the Nursing Home Administrator 1 (NHA) and the Director of Nursing 1 (DON) failed to timely and effectively manage 12 allegations of resident neglect and failed to maintain sufficient nursing staff to provide resident care and treatment, which created an Immediate Jeopardy situation for 12 of 12 residents (Resident R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, and R12), and failed to ensure annual abuse and neglect prevention training was completed for five of seven staff members (Nurse Aide (NA) Employee E1, Registered Nurse (RN) Employee E3, NA Employee E4, RN Employee E6, and the Director of Nursing (DON) identified in an incident of reported neglect, and failed to provide documentation of annual abuse and neglect training for 90 of 90 current Facility Employees for 12 of 12 months (January through December 2025), and failed to screen potential employees for a history of abuse by completing pre-employment criminal background checks for one of seven employees (Licensed Practical Nurse (LPN) Employee E2), and failed to verify current, valid license from licensing and registration boards to verify any disciplinary actions prior to employment for five of seven employees (NA Employee E1, RN Employee E3, NA Employee E4, RN Employee E6, and the DON) resulting in an Immediate Jeopardy for 66 of 66 residents Findings include:</p> <p>The job description for the Nursing Home Administrator indicated the NHA leads and directs the operations of the healthcare facility in accordance with local, state and federal regulations, standards, and established facility policies and procedures to provide appropriate care and services to residents. Plans, develop, organize, implement, evaluate, and direct the overall operation of the facility. Performs rounds to observe residents and ensure overall needs are met. Promotes and encourages and environment of trust among all employees related to the goal of resident safety and abuse prevention.</p> <p>The job description for the Director of Nursing dated 12/9/24, indicated the DON is to plan, organize, develop, and direct the overall operations of the nursing service department. Establish facility policies and procedures and provide appropriate care and services to the residents. Plans, develops, organizes, implements, evaluates, and directs the overall operations of the nursing services department. Ensures delivery of compassionate quality care and nursing supervision as evidenced by adequate staff coverage on the units. Performs rounds to observe residents and ensure nursing needs are being met. Monitors for allegations of potential abuse or neglect and participate in the investigative process.</p> <p>Based on findings identified, the facility failed to timely and effectively manage 12 allegations of resident neglect, failed to maintain sufficient nursing staff to provide resident care and treatment resulting in an Immediate Jeopardy for 12 of 12 residents, and failed to ensure annual abuse and neglect prevention training was completed for five of seven staff members (Nurse Aide (NA) Employee E1, Registered Nurse (RN) Employee E3, NA Employee E4, RN Employee E6, and the Director of Nursing (DON) identified in an incident of reported neglect, and failed to provide documentation of annual abuse and neglect training for 90 of 90 current Facility Employees for 12 of 12 months (January through December 2025), and failed to screen potential employees for a history of abuse by completing pre-employment criminal background checks for one of seven employees (Licensed Practical Nurse (LPN) Employee E2), and failed to verify current, valid license from licensing and registration boards to verify any disciplinary actions prior to employment for five of seven employees (NA Employee E1, RN Employee E3, NA Employee E4, RN Employee E6, and the DON) resulting in an Immediate Jeopardy for 66 of 66 residents. The NHA 1 and the DON 1 failed to fulfill their essential job duties to ensure the</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>federal and state guidelines and regulations were followed.</p> <p>During an interview on 1/14/26, at 7:00 p.m. the NHA 1 and DON 1 was notified that they failed to timely and effectively manage 12 allegations of resident neglect and failed to maintain sufficient nursing staff to provide resident care and treatment, which created an Immediate Jeopardy situation for 12 of 12 residents.</p> <p>During an interview on 1/18/26, at 3:49 p.m. the NHA 1 was made aware that an Immediate Jeopardy situation existed which created an Immediate Jeopardy for 66 of 66 residents.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1)(3)(e)(1) Management.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident clinical records and staff interviews it was determined that the facility failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for two of two residents (Resident R16 and R17). Findings include: Review of facility policy Coordination of Hospice services dated 9/29/25, indicated: When a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being. The facility maintains written agreements with hospice providers that specify the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the resident's care. The facility and hospice provider will coordinate a plan of care and will implement interventions in accordance with the resident's needs, goals, and recognized standards of practice in consultation with the resident's attending physician/practitioner and resident's representative, to the extent possible. The plan of care will identify the care and services that each entity will provide in order to meet the needs of the resident and his/her expressed desire for hospice care. The hospice provider retains primary responsibility for the provision of hospice care and services that are necessary for the care of the resident's terminal illness and related conditions. The facility retains primary responsibility for implementing those aspects of care that are not related to the duties of the hospice. The facility will communicate with hospice and identify, communicate, follow and document all interventions put into place by hospice and the facility. Review of the clinical record indicated Resident R16 was admitted to the facility on [DATE]. Review of Resident R16's MDS (minimum data set - a periodic assessment of resident needs) dated 11/3/25, indicated diagnosis of heart failure (occurs when the heart's muscle doesn't pump blood as well as it should) and depression (common and serious mental disorder that negatively affects how you feel, think, and act). Review of Resident R16's clinical record indicated he was admitted to hospice on 10/29/25. Review of Resident R16's clinical record indicated that hospice staff was last in the facility to provide care in 11/20/25. No other hospice documentation was noted in Resident R16's clinical record. During an interview on 1/19/26, at 12:19 p.m. LPN (licensed Practical Nurse) Employee E10 confirmed that Resident R16 continues to receive hospice services, and they were in providing care to resident R16 today. During an interview on 1/19/26 at 12:21 p.m. LPN Employee E10 confirmed that there was no clinical documentation past 11/20/25 from the hospice company and the facility failed to ensure a and they saw hospice staff in today for Resident R16. Review of clinical record indicated Resident R17 was admitted to the facility on [DATE]. Review of Resident R17's MDS dated [DATE], indicated diagnosis of traumatic brain injury (refers to a brain injury that is caused by an outside force) and seizure disorder (a sudden burst of electrical activity in the brain). Review of Resident R17's clinical record indicated she was admitted to hospice on 12/16/25. Review of Resident R17's clinical record, care plans failed to include a care plan for hospice. During an interview on 1/19/26, Registered Nurse (RN) Employee E6, confirmed that Resident R17 was still on hospice and receiving care from the hospice service. During an interview on 1/19/26, RN Employee E6 confirmed that the facility failed to implement a care plan for Resident R17 hospice needs. 28 Pa. Code:211.12 (d)(3)(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 - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to maintain proper infection control practices related to the care of clean linen, which created the potential for cross-contamination for one of two nursing floors (Second floor). Findings include: Review of facility policy Handling Clean Linen dated 9/22/25, indicated that the facility will handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection. During a tour of the second floor on 1/14/26, at 11:30 a.m. an empty clean linen cart was observed sitting by the exit stairwell door. During an interview on 1/14/26, at 11:35 a.m. Nurse Aide Employee E1 stated staff are using the empty clean linen cart to transport meal trays to residents' room and proceeded to show the state agency where linen was being kept. During an observation on 1/14/26, at 11:38 a.m. bedside tables were stored in a corridor with clean linen on them and the linen was uncovered. During an observation on 1/14/26, at 11:41 a.m. the resident's common room, on the second floor, had stacks of clean linen on the table, including towels, wash towels, and gowns and the linen was uncovered. During an interview on 1/14/26, at 11:46 a.m. the Environmental Director Employee E13 stated, I didn't authorize them to use the clean linen carts for meal trays. You can't leave linens uncovered anywhere. During an interview on 1/14/26, at 2:22 p.m. the Director of Nursing 1 confirmed that the facility failed to maintain proper infection control practices related to the care of clean linen, which created the potential for cross-contamination for one of two nursing floors (Second floor). 28 Pa. code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b) (1) (e) (1) Management. 28 Pa. Code: 211.10 (d) Resident care policies. 28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p>Based on review of facility documentation and staff and resident interviews, it was determined that the facility failed to maintain the facilities elevator (Main elevator) in safe operating condition for 11 of 11 days (January 6, 2026, through January 14, 2026). Findings include: The facility Elevator Use and Out-of-Service policy dated 9/22/25, indicated this policy is to ensure the safe and efficient use of the elevator at facility, maintain accessibility for residents and staff, and provide clear procedures when the elevator is out of service. This policy applies to all staff, residents, visitors, contractors, and vendors in the facility. Upon entrance to the facility on 1/14/26, at 9:00 a.m. the elevator on the Main floor was not functional and had a sign that stated, Do not use. During a review of facility provided documentation on 1/14/26, at 9:30 a.m. revealed on 1/6/26, Nursing Home Administrator (NHA) was notified by Plant Ops Director that the elevator was not functioning. Elevator service call was placed and came to facility same day. There was no disruption to resident service for appointments. All non-emergency appointments will be rescheduled. No disruption to meal service, meals served via assembly line upstairs. If a resident experiences an emergency, EMS will use transport devices for stairs. No negative outcomes identified. Will update once parts are ordered and installed. Parts are due to be ordered by elevator company 1/7/26 and overnighted so repairs can be done as soon as possible, early as 1/8/26. UPDATE 1/8/26: Parts were ordered this morning by elevator vendor and facility paid 50% down and parts are being ordered and overnighted in the AM, so the elevator is scheduled to be back up and running tomorrow 1/9/26. Update: Elevator was fixed on 1/16/2026. During an interview on 1/14/26, at 9:45 Maintenance Director Employee E12 stated, If a resident on the second floor needed to exit, they would have to come down the stairs and if visitors came to visit residents on the second floor, they would have to go up a flight of stairs because the elevator is broke and not working. During an interview on 1/14/26, at 10:25 a.m. NHA-1 stated she has to find another elevator company to fix the elevator because the original elevator company, that a payment was made to, is not taking or returning any calls from the facility and confirmed that the facility failed to maintain the facilities elevator (Main elevator) in a safe operating condition for 11 of 11 days (January 6, 2026, through January 14, 2026). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3) Management.</p>		

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<p>F 0941</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members.</p> <p>Based on review of facility policy, facility documents and staff interviews, it was determined that the facility failed to provide Communication training to four of five direct care facility staff reviewed (Employees E1, E3, E4, and E6). Finding include: Review of the facility policy Continuing Education dated 9/22/25, indicated that all levels of employees are expected to complete required trainings within designated time frames. During an interview on 1/16/25, at 1:52 p.m. Human Resources Director Employee E5 stated that education is conducted by calendar year running January through December. Review of facility education documents for the year 2025 revealed the following concerns: Review of Nurse Aide (NA) Employee E1's facility provided information did not include training on effective communication. Review of Registered Nurse (RN) Employee E3's facility provided information did not include training on effective communication. Review of NA Employee E4's facility provided information did not include training on effective communication. Review of RN Employee E6's facility provided information did not include training on effective communication. During an interview on 1/18/26, at 11:24 a.m. the Nursing Home Administrator confirmed that the facility failed to provide Communication training to direct care facility staff. 28 Pa. Code: 201.14(a) Responsibility of Licensee 28 Pa. Code: 201.20(c) Staff Development</p>		

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<p>F 0942</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents.</p> <p>Based on review of facility policy, facility documents and staff interviews, it was determined that the facility failed to provide Resident Rights training to four of five direct care facility staff reviewed (Employees E1, E3, E4, and E6). Finding include: Review of the facility policy Continuing Education dated 9/22/25, indicated that all levels of employees are expected to complete required trainings within designated time frames. During an interview on 1/16/25, at 1:52 p.m. Human Resources Director Employee E5 stated that education is conducted by calendar year running January through December. Review of facility education documents for the year 2025 revealed the following concerns: Review of Nurse Aide (NA) Employee E1's facility provided information did not include training on Resident Rights. Review of Registered Nurse (RN) Employee E3's facility provided information did not include training on Resident Rights. Review of NA Employee E4's facility provided information did not include training on Resident Rights. Review of RN Employee E6's facility provided information did not include training on Resident Rights. During an interview on 1/18/26, at 11:24 a.m. the Nursing Home Administrator confirmed that the facility failed to provide Resident Rights training to direct care facility staff. 28 Pa. Code: 201.14(a) Responsibility of Licensee 28 Pa. Code: 201.20(c) Staff Development</p>

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 01/22/2026
NAME OF PROVIDER OR SUPPLIER Spring Hill Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2170 Rhine Street Pittsburgh, PA 15212	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>Based on review of facility policy, facility documents and staff interviews, it was determined that the facility failed to provide Abuse and Neglect training to five of seven direct care facility staff reviewed (Employees E1, E3, E4, E6, and Director of Nursing). Finding include: Review of the facility policy Continuing Education dated 9/22/25, indicated that all levels of employees are expected to complete required trainings within designated time frames. During an interview on 1/16/25, at 1:52 p.m. Human Resources Director Employee E5 stated that education is conducted by calendar year running January through December. Review of facility education documents for the year 2025 revealed the following concerns: Review of Nurse Aide (NA) Employee E1's facility provided information did not include training on Abuse and Neglect. Review of Registered Nurse (RN) Employee E3's facility provided information did not include training on Abuse and Neglect. Review of NA Employee E4's facility provided information did not include training on Abuse and Neglect. Review of RN Employee E6's facility provided information did not include training on Abuse and Neglect. Review of the Director of Nursing's facility provided information did not include training on Abuse and Neglect. During an interview on 1/18/26, at 11:24 a.m. the Nursing Home Administrator confirmed that the facility failed to provide Abuse and Neglect training to direct care facility staff. 28 Pa. Code: 201.14(a) Responsibility of Licensee 28 Pa. Code: 201.20(c) Staff Development</p>

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<p>F 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>Based on review of facility policy, facility documents and staff interviews, it was determined that the facility failed to provide Quality Assurance and Performance Improvement (QAPI) training to five of five direct care facility staff reviewed (Employees E1, E2, E3, E4, and E6). Finding include: Review of the facility policy Continuing Education dated 9/22/25, indicated that all levels of employees are expected to complete required trainings within designated time frames. During an interview on 1/16/25, at 1:52 p.m. Human Resources Director Employee E5 stated that education is conducted by calendar year running January through December. Review of facility education documents for the year 2025 revealed the following concerns: Review of Nurse Aide (NA) Employee E1's facility provided information did not include training on QAPI. Review of Licensed Practical Nurse (LPN) Employee E2's facility provided information did not include training on QAPI. Review of Registered Nurse (RN) Employee E3's facility provided information did not include training on QAPI. Review of NA Employee E4's facility provided information did not include training on QAPI. Review of RN Employee E6's facility provided information did not include training on QAPI. During an interview on 1/18/26, at 11:24 a.m. the Nursing Home Administrator confirmed that the facility failed to provide QAPI training to direct care facility staff. 28 Pa. Code: 201.14(a) Responsibility of Licensee 28 Pa. Code: 201.20(c) Staff Development</p>		

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<p>F 0945</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program.</p> <p>Based on review of facility policy, facility documents and staff interviews, it was determined that the facility failed to provide Infection Control training to four of five direct care facility staff reviewed (Employees E1, E3, E4, and E6). Finding include: Review of the facility policy Continuing Education dated 9/22/25, indicated that all levels of employees are expected to complete required trainings within designated time frames. During an interview on 1/16/25, at 1:52 p.m. Human Resources Director Employee E5 stated that education is conducted by calendar year running January through December. Review of facility education documents for the year 2025 revealed the following concerns: Review of Nurse Aide (NA) Employee E1's facility provided information did not include training on Infection Control. Review of Registered Nurse (RN) Employee E3's facility provided information did not include training on Infection Control. Review of NA Employee E4's facility provided information did not include training on Infection Control. Review of RN Employee E6's facility provided information did not include training on Infection Control. During an interview on 1/18/26, at 11:24 a.m. the Nursing Home Administrator confirmed that the facility failed to provide Infection Control training to direct care facility staff. 28 Pa. Code: 201.14(a) Responsibility of Licensee 28 Pa. Code: 201.20(c) Staff Development</p>		

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<p>F 0946</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide training in compliance and ethics.</p> <p>Based on review of facility policy, facility documents and staff interviews, it was determined that the facility failed to provide Compliance and Ethics training to four of five direct care facility staff reviewed (Employees E1, E3, E4, and E6). Finding include: Review of the facility policy Continuing Education dated 9/22/25, indicated that all levels of employees are expected to complete required trainings within designated time frames. During an interview on 1/16/25, at 1:52 p.m. Human Resources Director Employee E5 stated that education is conducted by calendar year running January through December. Review of facility education documents for the year 2025 revealed the following concerns: Review of Nurse Aide (NA) Employee E1's facility provided information did not include training on Compliance and Ethics. Review of Registered Nurse (RN) Employee E3's facility provided information did not include training on Compliance and Ethics. Review of NA Employee E4's facility provided information did not include training on Compliance and Ethics. Review of RN Employee E6's facility provided information did not include training on Compliance and Ethics. During an interview on 1/18/26, at 11:24 a.m. the Nursing Home Administrator confirmed that the facility failed to provide Compliance and Ethics training to direct care facility staff. 28 Pa. Code: 201.14(a) Responsibility of Licensee 28 Pa. Code: 201.20(c) Staff Development</p>

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 01/22/2026
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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>Based on review of facility policy, personnel records, and staff interview it was determined that the facility failed to ensure that two of two sampled Nurse Aides (NA) received a minimum of 12 hours of in-service education per year (NA Employee E1, and E4). Findings include: Review of the facility policy Continuing Education dated 9/22/25, indicated that all levels of employees are expected to complete required trainings within designated time frames. During an interview on 1/16/25, at 1:52 p.m. Human Resources Director Employee E5 stated that education is conducted by calendar year running January through December. Review of facility education documents for the year 2025 revealed the following concerns: Review of personnel records revealed that NA Employee E1 did not receive 12 hours of in-service training in the last year. Review of personnel records revealed that NA Employee E4 did not receive 12 hours of in-service training in the last year. The facility was unable to provide documented evidence that NA Employees E1, and E4 had received a minimum of 12 hours of in-service training yearly. During an interview on 1/18/26, at 11:24 a.m. the Nursing Home Administrator confirmed that the facility failed to provide evidence that NA Employees E1, and E4 received the required 12 hours of yearly in-service training 28 Pa. Code: 201.14(a) Responsibility of Licensee. 28 Pa. Code: 201.20(c) Staff Development.</p>

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<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide behavior health training consistent with the requirements and as determined by a facility assessment.</p> <p>Based on review of facility policy, facility documents and staff interviews, it was determined that the facility failed to provide Behavioral Health training to four of five direct care facility staff reviewed (Employees E1, E3, E4, and E6). Finding include: Review of the facility policy Continuing Education dated 9/22/25, indicated that all levels of employees are expected to complete required trainings within designated time frames. During an interview on 1/16/25, at 1:52 p.m. Human Resources Director Employee E5 stated that education is conducted by calendar year running January through December. Review of facility education documents for the year 2025 revealed the following concerns: Review of Nurse Aide (NA) Employee E1's facility provided information did not include training on Behavioral Health. Review of Registered Nurse (RN) Employee E3's facility provided information did not include training on Behavioral Health. Review of NA Employee E4's facility provided information did not include training on Behavioral Health. Review of RN Employee E6's facility provided information did not include training on Behavioral Health. During an interview on 1/18/26, at 11:24 a.m. the Nursing Home Administrator confirmed that the facility failed to provide Behavioral Health training to direct care facility staff. 28 Pa. Code: 201.14(a) Responsibility of Licensee 28 Pa. Code: 201.20(c) Staff Development</p>		