STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395666	A. Building B. Wing	02/26/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, observations, and resident interviews, it was determined that the facility failed to ensure that residents rights were maintained in having beds in working order for residents to maintain the highest level of functioning for one of two residents (Resident R1).Findings include: Review of the Resident Rights policy dated 9/22/25, indicated the facility will inform the resident of his or her resident rights during the stay in the facility. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely. Review of Resident R1's admission record indicated she was admitted to the facility on [DATE]. Review of the Resident R1's Minimum Data Set (MDS- periodic assessment of resident care needs) dated 1/10/26, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and depression. Review of Resident R1's physician orders dated 9/29/25, indicated low air loss mattress to bed. Check placement and functioning every shift. During an interview on 2/25/26, at 1:50 p.m. Resident R1 stated, On Sunday (2/22/26), the motor for the foot part of my bed broke. I haven't been able to put my legs up or down while I'm in bed. During an observation on 2/25/26, at 1:55 p.m. when Resident R1 used the bed control to move the leg area of the bed up and down, the bed made a loud noise, and the bottom of the bed did not move up or down. During an interview on 2/25/26, at 2:07 p.m. Maintenance Director Employee E3 stated his department was notified that Resident R1's bed was broken and needed a new motor to control the lower portion of his bed. I took the specs off the bed to put an order in to purchase a new motor. I don't know if it's been ordered and confirmed that Resident R1's bed was not in working order. During an interview on 2/25/26, at 3:15 p.m. Director of Nursing confirmed that the facility failed to maintain resident rights in having a bed in working condition for one of two residents (Resident R1). 28 Pa. Code 211.10(a)(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, review of clinical records, resident interviews, and staff interviews, it was determined that the facility failed to ensure that residents are free from misappropriation of property for five of seven residents (Resident R1, R2, R3, R4, and R5). Findings include: Review of the facility policy Abuse, Neglect, &; Exploitation dated 9/22/25, indicated the facility will protect the health and welfare and rights of each resident by developing and implementing written policies and procedures that prohibit abuse, neglect, exploitation, and misappropriation of resident property. Misappropriation of resident property is defined as the deliberate misplacement, exploitation or wrongful use or a resident's belongings or money without the resident's consent. Review of the facility policy Medication Ordering and Receiving from Pharmacy dated 9/22/25, indicated medication classification as controlled substances by state law, are subject to special ordering, receipt, and recordkeeping requirements in the facility. Review of the clinical record revealed that Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - periodic assessment of care needs) dated 1/10/26, included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and depression. Review of Resident R1's physician's order dated 11/26/25, revealed MS Contin (pain medication) 15 milligrams (mg) by mouth at bedtime for chronic pain. Review of Resident R1's physician's order dated 11/26/25, revealed MS Contin 30 mg by mouth twice daily. Review of Resident R1's physician's order dated 12/23/25, revealed Oxycodone (pain medication) 5 mg by mouth every eight hours as needed for moderate to severe pain. During a review of Resident R1's clinical record on 2/25/26, at 3:30 p.m. revealed a discrepancy between the narcotic count on the controlled substance record for MS Contin 15 mg at bedtime. The documented record indicated that on 2/21/26, resident was given two tablets. The starting narcotic count was 25 and the ending count was 21. During a review of Resident R1's clinical record on 2/25/26, at 3:35 p.m. revealed a discrepancy between the narcotic count on the controlled substance record for MS Contin 30 mg twice a day. The documented record indicated that on 2/21/26 and 2/22/26, resident was given three tablets. The starting narcotic count was 18 and the ending count was 11. During a review of Resident R1's clinical record on 2/25/26, at 2:15 p.m. failed to reveal a controlled substance record for Oxycodone 5mg every eight hours as needed from 1/18/26 through 2/25/26. During an interview on 2/26/26, at 12:15 p.m. pharmacy representative confirmed that Resident R1 received 18 Oxycodone 5 mg tablets on 1/20/26. Review of the clinical record revealed that Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS dated [DATE], included diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), and osteoarthritis (degeneration of the joint causing pain and stiffness). Review of Resident R2's physician's order dated 11/23/25, revealed Oxycodone 7.5mg by mouth every eight hours as needed for moderate to severe pain. During a review of Resident R2's clinical record on 2/25/26, at 3:38 p.m. revealed a discrepancy between the narcotic count on the controlled substance record for Oxycodone 7.5 mg every eight hours as needed. The document record indicated that on 2/21/26 and 2/22/26, resident was given one tablet. The starting narcotic count was 40 and the ending count was 36. Review of the clinical record revealed that Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS dated [DATE], included diagnoses of high blood pressure, depression, and spina bifida (a congenital tube defect when the spine and spinal canal do not close completely). Review of Resident R3's physician's order dated 10/29/25, (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed MS Contin 15 mg by mouth three times daily. During a review of Resident R3's clinical record on 2/25/26, at 3:44 p.m. revealed a discrepancy between the narcotic count on the controlled substance record for MS Contin 15 mg three times a day. The record indicated that on 2/21/26 and 2/22/26, resident was given two tablets. The starting narcotic count was 38 and the ending count was 32. Review of the clinical record revealed that Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's MDS dated [DATE], included diagnoses of high blood pressure, depression, and neuropathy (damage to nerves outside the brain and spinal cord resulting in pain, numbness, tingling, or weakness, unusually in the hands and feet). Review of Resident R4's physician's order dated 2/19/26, revealed Oxycodone 5mg by mouth every 12 hours as needed for moderate to severe pain. During a review of Resident R4's clinical record on 2/25/26, at 3:50 p.m. revealed a discrepancy between the narcotic count on the controlled substance record for Oxycodone 5mg every 12 hours as needed. The record indicated that on 2/21/26, resident was given one tablet. The starting narcotic count was 12 and the ending count was 9. Review of the clinical record revealed that Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's MDS dated [DATE], included diagnoses of heart failure, COPD, and muscle spasms. Review of Resident R5's physician's order dated 12/24/25, revealed Oxycodone 10 mg by mouth three times daily. During a review of Resident R5's clinical record on 2/25/26, at 3:55 p.m. revealed a discrepancy between the narcotic count on the controlled substance record for Oxycodone 10mg three times a day. The document record indicated that on 2/21/26 and 2/22/26, resident was given four tablets. The starting narcotic count was six and the ending count was two. Resident was reported sleeping all night. During an interview on 2/25/26, at 2:30 p.m. the State Agency (SA) was made aware that there had been some missing narcotics from 2/21/26, and 2/22/26, and that the police were at the facility. During a review of documentation provided by the facility on 2/25/26, at 3:00 p.m. failed to reveal that missing narcotics were reported to the Department of Health. During an interview on 2/25/26, at 3:15 p.m. the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that Agency Registered Nurse (RN) Employee E1worked over the weekend and allegedly took multiple residents narcotics. The DON stated that he had an investigation of the incident in his office and a copy was requested by the SA. During an interview on 2/25/26, at 4:45 p.m. the DON stated that he failed to have an investigation of the allegation of narcotic diversion, however had copies of five residents (Resident R1, R2, R3, R4, and R5) controlled substance records that revealed the narcotic count discrepancies. During an interview on 2/26/26, at 1:10 p.m. RN Supervisor Employee E6 stated on 2/21/26, I worked a double (day and evening shift). Agency RN Employee E1 worked 2/21/26, at 7:00 p.m. until 2/22/26, at 7:00 a.m. The oncoming nurse, RN Employee E7, that was relieving RN Employee E1 came to me and said there was a problem with the narcotic count. Resident R2 was to have 40 Oxycodone 7.5 mg tablets and the count was 36. Agency RN Employee E1 stated that she may have given two tablets to Resident R2, and we asked her where the other two tablets were and was given no answer. I called the DON and made him aware of the incident. RN Employee E6 and RN Employee E7 corrected the narcotic count so she could start passing her medication. Later in the morning, RN Employee E8 came to me and stated that her narcotic counts were correct, however looking at the controlled substance record she noticed some discrepancies. I didn't have to do a corrected count with RN Employee E8 because the count was correct, but the documentation was wrong. I got a statement from Agency RN Employee E1, and then she left. She appeared kind of jumpy, crying and shaky when she left. During an interview on 2/26/26, at 2:31 p.m. RN Employee E7 stated I came in to work on 2/22/26, RN Employee E1 appeared shaky, high strung. I asked how residents were overnight. She stated Quiet. RN Employee E1 was standing with the narcotic book, and I was looking at the narcotic cards. During the (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	narcotic count, I noticed Resident R2's Oxycodone count was incorrect. RN Employee E1 stated there should be 40 tablets and there were only 36 in narcotic medication card. I alerted RN supervisor Employee E6. RN Employee E1 stated that she may have given Resident R2 a double dose of Oxycodone. I said, Well that is two tablets and the count should be 38, what about the other two tablets? The RN Employee E1 showed RN Employee E7 a medication cup that had two pills in it and stated, here they are. RN Employee E7 stated they were not Oxycodone. RN Employee E1 wrote a statement. When RN Employee E1 was finished, she walked past me crying and stated this is terrible, this is the worst. I notified physician of possible med error and monitored Resident R2 throughout my shift. During an interview on 2/27/26, at 9:15 a.m. RN Employee E8 stated I was very worked up. I only work weekends. I work 7:00 a.m. to 7:00 p.m. They put me on the same cart. I didn't notice any discrepancies initially because when we counted, she had the book and I was doing the meds. During the initial count everything was correct and then she went to count with someone else. Later in the day, I started to see discrepancies in the documentation on the controlled substance record. For example, Resident R3's narcotic count went from 38, to 35, and then ended with 32. Another one , Resident R5's, said he was given Oxycodone all throughout the night but it was reported to me that he slept all night. I don't believe he got any medication. Another resident, Resident R4's, Oxycodone started at 12 and ended with nine. The initial narcotic counts matched but the narcotic sheets were not signed out correctly. During an interview on 2/26/26, at 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure that residents are free from misappropriation of property for five of seven residents (Resident R1, R2, R3, R4, and R5). 28 Pa. Code: 211.12 (d)(1)(5) Nursing services. 28 Pa. Code: 201.29(a) Resident rights.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on reviews of facility policy, employee files, facility documentation, and staff interviews, it was determined that the facility failed to verify current, valid license from licensing and registration boards to verify any disciplinary actions prior to employment for one of two employees (Registered Nurse Employee E1). Findings include: Review of facility policy Abuse, Neglect, and Exploitation reviewed 9/22/25, indicated that the facility will protect the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit ad prevent abuse, neglect, exploitation, and misappropriation of resident property. A potential employee will be screened for a history of abuse, neglect, exploitation, and misappropriation of residential property. Screenings may be conducted by the facility. The facility will maintain documentation of proof that the screening occurred. Review of facility policy Licensed Nurse Credentialing and License Verification reviewed 9/22/25, indicated all licensed nurses will have their credentials and license verified upon employment. During an interview on 2/25/26, at 3:16 p.m. Director of Nursing confirmed that Registered Nurse (RN) Employee E1 was an agency nurse who worked in the facility 2/21/26 through 2/22/26. During a review of RN Employee E1 personnel folder on 2/26/26, at 10:15 a.m. included a license verification that was conducted on 2/24/26, three days after working in the facility. During an interview on 2/26/26, at 2:40 p.m. the Human Resources Employee E2 confirmed that the facility failed to have documented evidence of license verification prior to first working shift for RN Employee E1. 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.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident clinical record, incident reports, reports submitted to the State, and staff interview it was determined that the facility failed to report allegations of misappropriation of resident belongings for five of seven residents (Resident R1, R2, R3, R4, and R5). Findings include: Review of the facility policy Abuse, Neglect, &; Exploitation dated 9/22/25, indicated the facility will protect the health and welfare and rights of each resident by developing and implementing written policies and procedures that prohibit abuse, neglect, exploitation, and misappropriation of resident property. Misappropriation of resident property is defined as the deliberate misplacement, exploitation or wrongful use or a resident's belongings or money without the resident's consent. Review of the facility policy Medication Ordering and Receiving from Pharmacy dated 9/22/25, indicated medication classification as controlled substances by state law, are subject to special ordering, receipt, and recordkeeping requirements in the facility. Review of the clinical record revealed that Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - periodic assessment of care needs) dated 1/10/26, included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and depression. Review of Resident R1's physician's order dated 11/26/25, revealed MS Contin (pain medication) 15 milligrams (mg) by mouth at bedtime for chronic pain. Review of Resident R1's physician's order dated 11/26/25, revealed MS Contin 30 mg by mouth twice daily. Review of Resident R1's physician's order dated 12/23/25, revealed Oxycodone (pain medication) 5 mg by mouth every eight hours as needed for moderate to severe pain. During a review of Resident R1's clinical record on 2/25/26, at 3:30 p.m. revealed a discrepancy between the narcotic count on the controlled substance record for MS Contin 15 mg at bedtime. The documented record indicated that on 2/21/26, resident was given two tablets. The starting narcotic count was 25 and the ending count was 21. During a review of Resident R1's clinical record on 2/25/26, at 3:35 p.m. revealed a discrepancy between the narcotic count on the controlled substance record for MS Contin 30 mg twice a day. The documented record indicated that on 2/21/26 and 2/22/26, resident was given three tablets. The starting narcotic count was 18 and the ending count was 11. During a review of Resident R1's clinical record on 2/25/26, at 2:15 p.m. failed to reveal a controlled substance record for Oxycodone 5mg every eight hours as needed from 1/18/26 through 2/25/26. During an interview on 2/26/26, at 12:15 p.m. pharmacy representative confirmed that Resident R1 received 18 Oxycodone 5 mg tablets on 1/20/26. Review of the clinical record revealed that Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS dated [DATE], included diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), and osteoarthritis (degeneration of the joint causing pain and stiffness). Review of Resident R2's physician's order dated 11/23/25, revealed Oxycodone 7.5mg by mouth every eight hours as needed for moderate to severe pain. During a review of Resident R2's clinical record on 2/25/26, at 3:38 p.m. revealed a discrepancy between the narcotic count on the controlled substance record for Oxycodone 7.5 mg every eight hours as needed. The document record indicated that on 2/21/26 and 2/22/26, resident was given one tablet. The starting narcotic count was 40 and the ending count was 36. Review of the clinical record revealed that Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS dated [DATE], included diagnoses of high blood pressure, depression, and spina bifida (a congenital tube defect when the spine and spinal canal do not close completely). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R3's physician's order dated 10/29/25, revealed MS Contin 15 mg by mouth three times daily. During a review of Resident R3's clinical record on 2/25/26, at 3:44 p.m. revealed a discrepancy between the narcotic count on the controlled substance record for MS Contin 15 mg three times a day. The record indicated that on 2/21/26 and 2/22/26, resident was given two tablets. The starting narcotic count was 38 and the ending count was 32. Review of the clinical record revealed that Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's MDS dated [DATE], included diagnoses of high blood pressure, depression, and neuropathy (damage to nerves outside the brain and spinal cord resulting in pain, numbness, tingling, or weakness, unusually in the hands and feet). Review of Resident R4's physician's order dated 2/19/26, revealed Oxycodone 5mg by mouth every 12 hours as needed for moderate to severe pain. During a review of Resident R4's clinical record on 2/25/26, at 3:50 p.m. revealed a discrepancy between the narcotic count on the controlled substance record for Oxycodone 5mg every 12 hours as needed. The record indicated that on 2/21/26, resident was given one tablet. The starting narcotic count was 12 and the ending count was 9. Review of the clinical record revealed that Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's MDS dated [DATE], included diagnoses of heart failure, COPD, and muscle spasms. Review of Resident R5's physician's order dated 12/24/25, revealed Oxycodone 10 mg by mouth three times daily. During a review of Resident R5's clinical record on 2/25/26, at 3:55 p.m. revealed a discrepancy between the narcotic count on the controlled substance record for Oxycodone 10mg three times a day. The document record indicated that on 2/21/26 and 2/22/26, resident was given four tablets. The starting narcotic count was six and the ending count was two. Resident was reported sleeping all night. During an interview on 2/25/26, at 2:30 p.m. the State Agency (SA) was made aware that there had been some missing narcotics from 2/21/26, and 2/22/26, and that the police were at the facility. During a review of documentation provided by the facility on 2/25/26, at 3:00 p.m. failed to reveal that missing narcotics were reported to the Department of Health. During an interview on 2/25/26, at 3:15 p.m. the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that Agency Registered Nurse (RN) Employee E1worked over the weekend and allegedly took multiple residents narcotics. The DON stated that he had an investigation of the incident in his office and a copy was requested by the SA. During an interview on 2/25/26, at 4:45 p.m. the DON stated that he failed to have an investigation of the allegation of narcotic diversion, however had copies of five residents (Resident R1, R2, R3, R4, and R5) controlled substance records that revealed the narcotic count discrepancies. The DON failed to provide an investigation for reported misappropriation of resident belongings concerning missing narcotics on 2/21/26, and 2/22/26, and the DON confirmed that the facility did not investigate or report the incident. During an interview on 2/26/26, at 1:10 p.m. RN Supervisor Employee E6 stated on 2/21/26, I worked a double (day and evening shift). Agency RN Employee E1 worked 2/21/26, from 7:00 p.m. until 2/22/26, at 7:00 a.m. The oncoming nurse, RN Employee E7, that was relieving RN Employee E1 came to me and said there was a problem with the narcotic count. Resident R2 was to have 40 Oxycodone 7.5 mg tablets and the count was 36. Agency RN Employee E1 stated that she may have given two tablets to Resident R2, and we asked her where the other two tablets were and was given no answer. I called the DON and made him aware of the incident. RN Employee E6 and RN Employee E7 corrected the narcotic count so she could start passing her medication. Later in the morning, RN Employee E8 came to me and stated that her narcotic counts were correct, however looking at the controlled substance record she noticed some discrepancies. I didn't have to do a corrected count with RN Employee E8 because the count was correct, but the documentation was wrong. I got a statement from Agency RN Employee E1, and then she left. She appeared kind of jumpy, crying and shaky when she left. During an (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 2/26/26, at 2:31 p.m. RN Employee E7 stated I came in to work on 2/22/26, RN Employee E1 appeared shaky, high strung. I asked how residents were overnight. She stated Quiet. RN Employee E1 was standing with the narcotic book, and I was looking at the narcotic cards. During the narcotic count, I noticed Resident R2's Oxycodone count was incorrect. RN Employee E1 stated there should be 40 tablets and there were only 36 in narcotic medication card. I alerted RN supervisor Employee E6. RN Employee E1 stated that she may have given Resident R2 a double dose of Oxycodone. I said, Well that is two tablets and the count should be 38, what about the other two tablets? The RN Employee E1 showed RN Employee E7 a medication cup that had two pills in it and stated, here they are. RN Employee E7 stated they were not Oxycodone. RN Employee E1 wrote a statement. When RN Employee E1 was finished, she walked past me crying and stated this is terrible, this is the worst. I notified physician of possible med error and monitored Resident R2 throughout my shift. During an interview on 2/27/26, at 9:15 a.m. RN Employee E8 stated I was very worked up. I only work weekends. I work from 7:00 a.m. to 7:00 p.m. They put me on the same cart. I didn't notice any discrepancies initially because when we counted, she had the book and I was doing the meds. During the initial count everything was correct and then she went to count with someone else. Later in the day, I started to see discrepancies in the documentation on the controlled substance record. For example, Resident R3's narcotic count went from 38, to 35, and then ended with 32. Another one, Resident R5's, said he was given Oxycodone all throughout the night but it was reported to me that he slept all night. I don't believe he got any medication. Another resident, Resident R4's, Oxycodone started at 12 and ended with nine. The initial narcotic counts matched but the narcotic sheets were not signed out correctly. During an interview on 2/26/26, at 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to report allegations of misappropriation of resident belongings for five of seven residents (Resident R1, R2, R3, R4, and R5). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 201.18 (b) (1) (e) (1) Management. 28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.

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	395666	A. Building B. Wing	02/26/2026

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, facility policy, clinical records, and staff interview, it was determined that the facility failed to conduct a thorough investigation for allegations of misappropriation of resident belongings for five of seven residents (Resident R1, R2, R3, R4, and R5). Findings include: Review of the facility policy Abuse, Neglect, &; Exploitation dated 9/22/25, indicated the facility will protect the health and welfare and rights of each resident by developing and implementing written policies and procedures that prohibit abuse, neglect, exploitation, and misappropriation of resident property. Misappropriation of resident property is defined as the deliberate misplacement, exploitation or wrongful use or a resident's belongings or money without the resident's consent. Review of the facility policy Medication Ordering and Receiving from Pharmacy dated 9/22/25, indicated medication classification as controlled substances by state law, are subject to special ordering, receipt, and recordkeeping requirements in the facility. Review of the clinical record revealed that Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - periodic assessment of care needs) dated 1/10/26, included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and depression. Review of Resident R1's physician's order dated 11/26/25, revealed MS Contin (pain medication) 15 milligrams (mg) by mouth at bedtime for chronic pain. Review of Resident R1's physician's order dated 11/26/25, revealed MS Contin 30 mg by mouth twice daily. Review of Resident R1's physician's order dated 12/23/25, revealed Oxycodone (pain medication) 5 mg by mouth every eight hours as needed for moderate to severe pain. During a review of Resident R1's clinical record on 2/25/26, at 3:30 p.m. revealed a discrepancy between the narcotic count on the controlled substance record for MS Contin 15 mg at bedtime. The documented record indicated that on 2/21/26, resident was given two tablets. The starting narcotic count was 25 and the ending count was 21. During a review of Resident R1's clinical record on 2/25/26, at 3:35 p.m. revealed a discrepancy between the narcotic count on the controlled substance record for MS Contin 30 mg twice a day. The documented record indicated that on 2/21/26 and 2/22/26, resident was given three tablets. The starting narcotic count was 18 and the ending count was 11. During a review of Resident R1's clinical record on 2/25/26, at 2:15 p.m. failed to reveal a controlled substance record for Oxycodone 5mg every eight hours as needed from 1/18/26 through 2/25/26. During an interview on 2/26/26, at 12:15 p.m. pharmacy representative confirmed that Resident R1 received 18 Oxycodone 5 mg tablets on 1/20/26. Review of the clinical record revealed that Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS dated [DATE], included diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), and osteoarthritis (degeneration of the joint causing pain and stiffness). Review of Resident R2's physician's order dated 11/23/25, revealed Oxycodone 7.5mg by mouth every eight hours as needed for moderate to severe pain. During a review of Resident R2's clinical record on 2/25/26, at 3:38 p.m. revealed a discrepancy between the narcotic count on the controlled substance record for Oxycodone 7.5 mg every eight hours as needed. The document record indicated that on 2/21/26 and 2/22/26, resident was given one tablet. The starting narcotic count was 40 and the ending count was 36. Review of the clinical record revealed that Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS dated [DATE], included diagnoses of high blood pressure, depression, and spina bifida (a congenital tube defect when the spine and spinal canal do not close completely). Review of Resident R3's physician's order dated 10/29/25, revealed MS Contin (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	15 mg by mouth three times daily. During a review of Resident R3's clinical record on 2/25/26, at 3:44 p.m. revealed a discrepancy between the narcotic count on the controlled substance record for MS Contin 15 mg three times a day. The record indicated that on 2/21/26 and 2/22/26, resident was given two tablets. The starting narcotic count was 38 and the ending count was 32. Review of the clinical record revealed that Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's MDS dated [DATE], included diagnoses of high blood pressure, depression, and neuropathy (damage to nerves outside the brain and spinal cord resulting in pain, numbness, tingling, or weakness, unusually in the hands and feet). Review of Resident R4's physician's order dated 2/19/26, revealed Oxycodone 5mg by mouth every 12 hours as needed for moderate to severe pain. During a review of Resident R4's clinical record on 2/25/26, at 3:50 p.m. revealed a discrepancy between the narcotic count on the controlled substance record for Oxycodone 5mg every 12 hours as needed. The record indicated that on 2/21/26, resident was given one tablet. The starting narcotic count was 12 and the ending count was 9. Review of the clinical record revealed that Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's MDS dated [DATE], included diagnoses of heart failure, COPD, and muscle spasms. Review of Resident R5's physician's order dated 12/24/25, revealed Oxycodone 10 mg by mouth three times daily. During a review of Resident R5's clinical record on 2/25/26, at 3:55 p.m. revealed a discrepancy between the narcotic count on the controlled substance record for Oxycodone 10mg three times a day. The document record indicated that on 2/21/26 and 2/22/26, resident was given four tablets. The starting narcotic count was six and the ending count was two. Resident was reported sleeping all night. During an interview on 2/25/26, at 2:30 p.m. the State Agency (SA) was made aware that there had been some missing narcotics from 2/21/26, and 2/22/26, and that the police were at the facility. During a review of documentation provided by the facility on 2/25/26, at 3:00 p.m. failed to reveal that missing narcotics were reported to the Department of Health. During an interview on 2/25/26, at 3:15 p.m. the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that Agency Registered Nurse (RN) Employee E1worked over the weekend and allegedly took multiple residents narcotics. The DON stated that he had an investigation of the incident in his office and a copy was requested by the SA. During an interview on 2/25/26, at 4:45 p.m. the DON stated that he failed to have an investigation of the allegation of narcotic diversion, however had copies of five residents (Resident R1, R2, R3, R4, and R5) controlled substance records that revealed the narcotic count discrepancies. The DON failed to provide an investigation for reported misappropriation of resident belongings concerning missing narcotics on 2/21/26, and 2/22/26, and the DON confirmed that the facility did not investigate it. During an interview on 2/26/26, at 1:10 p.m. RN Supervisor Employee E6 stated on 2/21/26, I worked a double (day and evening shift). Agency RN Employee E1 worked 2/21/26, at 7:00 p.m. until 2/22/26, at 7:00 a.m. The oncoming nurse, RN Employee E7, that was relieving RN Employee E1 came to me and said there was a problem with the narcotic count. Resident R2 was to have 40 Oxycodone 7.5 mg tablets and the count was 36. Agency RN Employee E1 stated that she may have given two tablets to Resident R2, and we asked her where the other two tablets were and was given no answer. I called the DON and made him aware of the incident. RN Employee E6 and RN Employee E7 corrected the narcotic count so she could start passing her medication. Later in the morning, RN Employee E8 came to me and stated that her narcotic counts were correct, however looking at the controlled substance record she noticed some discrepancies. I didn't have to do a corrected count with RN Employee E8 because the count was correct, but the documentation was wrong. I got a statement from Agency RN Employee E1, and then she left. She appeared kind of jumpy, crying and shaky when she left. During an interview on 2/26/26, at 2:31 p.m. RN Employee E7 stated I came in to work on 2/22/26, RN Employee (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E1 appeared shaky, high strung. I asked how residents were overnight. She stated Quiet. RN Employee E1 was standing with the narcotic book, and I was looking at the narcotic cards. During the narcotic count, I noticed Resident R2's Oxycodone count was incorrect. RN Employee E1 stated there should be 40 tablets and there were only 36 in narcotic medication card. I alerted RN supervisor Employee E6. RN Employee E1 stated that she may have given Resident R2 a double dose of Oxycodone. I said, Well that is two tablets and the count should be 38, what about the other two tablets? The RN Employee E1 showed RN Employee E7 a medication cup that had two pills in it and stated, here they are. RN Employee E7 stated they were not Oxycodone. RN Employee E1 wrote a statement. When RN Employee E1 was finished, she walked past me crying and stated this is terrible, this is the worst. I notified physician of possible med error and monitored Resident R2 throughout my shift. During an interview on 2/27/26, at 9:15 a.m. RN Employee E8 stated I was very worked up. I only work weekends. I work 7:00 a.m. to 7:00 p.m. They put me on the same cart. I didn't notice any discrepancies initially because when we counted, she had the book and I was doing the meds. During the initial count everything was correct and then she went to count with someone else. Later in the day, I started to see discrepancies in the documentation on the controlled substance record. For example, Resident R3's narcotic count went from 38, to 35, and then ended with 32. Another one , Resident R5's, said he was given Oxycodone all throughout the night but it was reported to me that he slept all night. I don't believe he got any medication. Another resident, Resident R4's, Oxycodone started at 12 and ended with nine. The initial narcotic counts matched but the narcotic sheets were not signed out correctly. During an interview on 2/26/26, at 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to conduct a thorough investigation of allegations of misappropriation of resident belongings for five of seven residents (Resident R1, R2, R3, R4, and R5). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10 (c)(d) Resident Care policies. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and clinical records, resident and staff interviews, it was determined that the facility failed to provide effective pain management for one of five residents reviewed (Resident R1), which resulted in excessive pain, poor sleeping, and decreased level of functioning of activities of daily living, causing harm to Resident R1.Findings include: Review of the facility policy Medication Ordering and Receiving from Pharmacy dated 9/22/25, indicated medications are administered in an organized and safe manner. Pour the correct number of tablets or capsules into the medication cup. Administer medication and remain with resident while medication is swallowed. Review of Resident R1's admission record indicated she was admitted to the facility on [DATE]. Review of the Resident R1's Minimum Data Set (MDS- periodic assessment of resident care needs) dated 1/10/26, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and depression. Review of Resident R1's care plan dated 7/17/25, revealed the resident was care planned for chronic pain. Interventions included to administer medication per physician orders. Review of Resident R1's physician order dated 12/23/25, indicated to administer Oxycodone (a pain medication) 5 milligrams, one tablet by mouth, every eight hours as needed. During an interview on 2/25/26, at 11:45 a.m. Resident R1 reported that he requested an Oxycodone for breakthrough pain and did not receive his Oxycodone Sunday, Monday, and Tuesday this week according to the physician order and stated, I was in a lot more pain than normal. It affected some activities that I do. I didn't do my laundry, I didn't sleep well. I didn't stay out of bed as long as I usually do. I was pretty miserable. During a review of Resident R1's clinical record on 2/25/26, revealed that the Medication Administration Record (MAR) was blank, which indicated that resident did not receive Oxycodone as needed. During a review of Resident R1's chart on 2/25/26, at 2:30 p.m. failed to contain the controlled substance record to review documentation of Oxycodone. During an interview on 2/25/26, at 2:35 p.m. Registered Nurse Employee E11 confirmed that the controlled substance record was missing and unable to identify if Resident R1 had Oxycodone given per request. During an interview on 2/26/26, at 2:55 p.m. Clinical Consultant Employee E9 reviewed February MAR and confirmed that 2/22/26, 2/23/26, and 2/24/26 were blank, indicating Resident R1 did not receive Oxycodone per request. During an interview on 2/26/26, at 3:00 p.m. Clinical Consultant Employee E9 confirmed that the facility failed to provide effective pain management for one of five residents reviewed (Resident R1), which resulted in excessive pain, poor sleeping, and decreased level of functioning of activities of daily living, causing harm to Resident R1. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review, resident interview, and staff interview it was determined that the facility failed to ensure that the pharmacy provided medications timely for one of two residents reviewed (Resident R1).Findings include: Review of the facility policy Medication Ordering and Receiving from Pharmacy dated 9/22/25, indicated medications are administered in an organized and safe manner. Pour the correct number of tablets or capsules into the medication cup. Administer medication and remain with resident while medication is swallowed. Review of Resident R1's admission record indicated she was admitted to the facility on [DATE]. Review of the Resident R1's Minimum Data Set (MDS- periodic assessment of resident care needs) dated 1/10/26, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and depression. During an interview on 2/25/26, at 11:45 a.m. Resident R1 stated that he should be receiving two Singulair (a medication used to treat allergies) 10 mg (milligram) tablets every day and that he has been only receiving one tablet. During a review of Resident R1's physician orders dated 1/25/26, revealed Singulair 10 mg, give two tablets every day. During an observation of Resident R1's medication on 2/26/26, at 11:20 a.m. with Clinical Consultant Employee E9 revealed that pharmacy is sending Singulair 10 mg, quantity one to be administered. During a phone interview on 2/26/26, at 11:41 a.m. Pharmacist Employee E10 confirmed that Resident R1 has been receiving Singulair 10 mg, one tablet and that the pharmacy cycle order is incorrect and stated that he will get it fixed. During an interview on 2/26/26, at 3:00 p.m. Clinical Consultant Employee E9 confirmed that the facility failed to ensure that the pharmacy provided medications timely for one of two residents reviewed (Resident R1). 28 Pa. Code211.12(d)(1)(3)(5) Nursing services.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job description, clinical records, observations, and staff interviews, it was determined that the Director of Nursing (DON) failed to timely and effectively manage five allegations of misappropriation of resident belongings that included narcotic diversion for five of five residents (Resident R1, R2, R3, R4, and R5). Findings include: 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. Based on findings identified, the facility failed to timely and effectively manage five of five allegations of misappropriation of resident belongings that included narcotic diversion. The DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 2/25/26, at 3:15 p.m. the DON stated he had the investigation of the incident upstairs in his office and would provide state agency (SA) with a copy. During an interview on 2/25/26, at 4:45 p.m. the DON confirmed that he failed to have an investigation for the misappropriation of resident belongings that included narcotic diversion for five of five residents. When SA asked the DON, Do you have an investigation concerning the narcotic diversion? the DON replied No. During an interview on 2/26/26, at 3.00 p.m. the NHA confirmed that the DON failed to timely and effectively manage five allegations of resident misappropriation of belongings which included narcotic diversion for five of five residents (Resident R1, R2, R3, R4, and R5). 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.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on a review of facility documents and interviews with staff it was determined that the facility failed to provide the State Agency with access to facility investigation, causing a delay in the survey process. Findings include: During a complaint survey on 2/25/26, at 9:00 a.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON) were made aware that the state agency (SA) team will be investigating five complaints. During an interview on 2/25/26, at 2:30 p.m. the SA was made aware that a nurse over the weekend was taking narcotics and that the police were notified. During an interview on 2/25/26, at 3:15 p.m. the Director of Nursing confirmed that a nurse had taken narcotics and that the police were notified on 2/22/26. The SA asked the DON for the facility's complete investigation for the incident to review. The DON stated, The investigation is in my office, I can go get it for you. The SA requested a copy of the full investigation at this time. During an interview on 2/25/26, at 3:55 p.m. the Interim Assistant Director of Nursing was made aware that SA was waiting for the DON's complete investigation of incident. During an interview on 2/25/26, at 4:11 p.m. the Nursing Home Administrator (NHA) was made aware that SA was waiting for the DON's complete investigation of incident. During an interview on 2/25/26, at 4:45 p.m. the DON confirmed that he failed to have an investigation for the misappropriation of resident belongings that included narcotic diversion for five of five residents. When SA asked the DON, Do you have an investigation concerning the narcotic diversion? the DON replied No. The SA asked, When you said your investigation was in your office and you would make a copy for review, you didn't have an investigation? the DON replied No. During an interview on 2/25/26, at 4:50 p.m. the NHA and DON confirmed that the facility did not have an investigation for five of five resident misappropriations of resident property that included narcotic diversion and were made aware that the extended amount of time waiting for the facilities investigation that did not exist was a delay in survey. The SA returned to facility on 2/26/26, at 8:30 a.m. to continue investigating the misappropriation of resident property. 28 Pa.Code 201.14(a) Responsibility for licensee. 28 Pa.Code 201.18(d)(e)(1) Management.