

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395719	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2025
NAME OF PROVIDER OR SUPPLIER Riverside Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 8th Street McKeesport, PA 15132	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to notify the resident representative of changes in condition for one of four residents (Resident R1).</p> <p>Findings include:</p> <p>Review of the facility, Resident Change in Condition Policy dated 1/2/24, indicated The physician/provider and resident/family/responsible party will be notified when there has been an accident or incident involving the resident.</p> <p>Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE].</p> <p>Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 4/10/25, included diagnoses of atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat) and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Section C: Cognitive Patterns indicated Resident R1 had severe cognitive impairment.</p> <p>Review of an incident report dated 6/14/25, indicated Resident R1 had a fall from his wheelchair. Review of the Notifications section of this report indicated that Resident R1's resident representative was not notified of the incident.</p> <p>Review of a progress note dated 6/14/25, at 5:33 p.m. indicated, CNA (nurse aide) stated she was pushing resident back to his room and slammed his feed down grabbed the railing on the wall causing him to fall fwd (forward) to the floor. CNA came to alert LPN (licensed practical nurse) who was in another resident's room assisting CNA with care. I approached resident and he was lying on his back with a small injury to his forehead.</p> <p>Review of a progress note dated 6/16/25, at 1:24 p.m. indicated, I contacted the wife to notify her of the resident's fall. Wife at the facility and she notified the bruise on her husband's face, so she already figured he had a fall.</p> <p>During an interview on 7/8/25, at approximately 2:15 p.m., the Nursing Home Administrator confirmed the facility failed to notify the resident representative of changes in condition for one of four residents.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, facility documents, and staff interview, it was determined that the facility failed to fully investigate injuries during care for and an injury of unknown origin possible neglect for three of four residents (Resident R1, R2, and R3).</p> <p>Findings include:</p> <p>Review of facility policy Abuse, Neglect and Exploitation dated 1/2/24, indicated it is that facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, intimidation, exploitation of residents, misappropriation of resident property and injuries of unknown source.</p> <p>Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE].</p> <p>Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 4/10/25, included diagnoses of atrial fibrillation and dementia. Review of Section C: Cognitive Patterns indicated Resident R1 had severe cognitive impairment. Review of Section GG: Functional Abilities indicated Resident R1 utilized a walker and a manual wheelchair.</p> <p>Review of Resident R1's plan of care for Risk for falling related to weakness dated 11/22/24, indicated to Out of bed to standard wheelchair with pressure redistribution cushion, bilateral elevating leg rests, rear anti-tippers, and anti-roll back system.</p> <p>Review of a progress note dated 6/14/25, at 5:33 p.m. indicated, CNA (nurse aide) stated she was pushing resident back to his room and slammed his feed down grabbed the railing on the wall causing him to fall fwd (forward) to the floor. CNA came to alert LPN (licensed practical nurse) who was in another resident's room assisting CNA with care. I approached resident and he was lying on his back with a small injury to his forehead.</p> <p>Review of a progress note dated 6/14/25, at 9:44 p.m. indicated, RNS (Registered Nurse Supervisor) called back to unit after resident had fallen from his wheelchair. Small laceration to mid forehead. Does not need sutures. MD notified.</p> <p>Review of a progress note dated 6/15/25, at 9:30 p.m. indicated, RN assessed head injury from fall on 6/14. Abrasion noted on mid forehead with small bum. Bump is tender to touch.</p> <p>Review of an employee statement dated 6/14/25, written by Nurse Aide (NA) Employee E3) stated, [Resident R1] asked staff me (NA Employee E3) to push him down the hall. As I was pushing him he abruptly slammed his feet down and leaned forward grabbing the rail yelling about him and roommate having their meals brought to room. [Resident R1] was still demanding staff bring a meal to his room while on floor. [Resident R1] has small abrasion in middle forehead. Staff assisted nurse with getting resident up.</p> <p>Review of an IDT (Inter-disciplinary team) note dated 6/16/25, at 9:42 a.m. indicated, Root Cause: Poor safety awareness related to dementia diagnosis. The preventative action/interventions were listed:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>OT (Occupational therapy) screen on 6/17.</p> <p>Fall Prevention program.</p> <p>Leg rests to wheelchair if resident does not self-propel.</p> <p>Review of the clinical record indicated Resident R2 was readmitted to the facility on [DATE].</p> <p>Review of the MDS dated [DATE], included diagnoses of debility, syncope (fainting or passing out) and collapse, and sequela (consequence of a previous disease or injury) of a fall. Review of Section GG: Functional Abilities indicated Resident R2 was not assessed by facility staff for Chair/bed-to-chair performance - the ability to transfer to and from a bed to a chair (or wheelchair). Review of the Section GG Supportive Documentation Tool dated 6/19/25, indicated Chair/bed-to-chair performance was not assessed due to Not attempted due to medical condition or safety concerns.</p> <p>Review of a physician's order dated 6/17/25, discontinued 6/18/25, indicated Resident R2 required a mechanical lift for transfers. No further orders were present after 6/18/25, to indicate appropriate transfer status. As of 7/8/25, Resident R2 does not have a physician's order for transfer status.</p> <p>Review of a progress note dated 6/24/25, at 5:00 a.m. indicated, Assigned CNA notified this nurse that resident requested to sit in his wheelchair, and he slid out of the wheelchair as CNA was assisting him. Upon observation, resident was sitting next to his bed on this buttocks with both legs extended out in front of him Resident was leaning against the locked wheelchair with a towel in the seat. Resident states he in fact did slide out of the wheelchair while CNA was assisting him, denies experienced any pain related to fall or hitting his head.</p> <p>Review of an employee statement dated 6/24/25, written by NA Employee E5 indicated, At 5:00 a.m. the resident wanted to sit in the wheelchair from the upon sitting in the wheelchair he slip from the chair and I lower him on the floor. I immediately called the Nurse on the sceam (scene).</p> <p>Review of a progress note dated 6/24/25, at 11:31 a.m. indicated, Root Cause: Towel on wheelchair causing resident to slide. The preventative action/interventions were listed:</p> <p>Continue with therapy as ordered</p> <p>Fall prevention program.</p> <p>Review of the clinical record indicated Resident R3 was readmitted to the facility on [DATE].</p> <p>Review of the MDS dated [DATE], included diagnoses of macular degeneration (vision loss in the center of the field of vision) and dementia. Review of Section C: Cognitive Patterns indicated Resident R3 had severe cognitive impairment.</p> <p>Review of a progress note dated 6/26/25, at 3:41 p.m. indicated, This nurse found a dressing on residents right arm this nurse removed it and found a 2x2 skin tear this did not happen this shift and no documentation as to when. MD notified son called and protocol followed. minor pain when dressing (the wound).</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 7/5/25, at 12:22 p.m. the facility was requested to provide the investigation into Resident R3's injury of unknown origin.</p> <p>On 7/8/25, the facility was only able to provide the incident report, with no investigation into when the skin tear occurred, what staff member placed a dressing on the wound, or employee statements.</p> <p>During an interview on 7/9/25, at approximately 1:20 p.m. the Director of Nursing confirmed the facility failed to fully investigate injuries during care for and an injury of unknown origin possible neglect for three of four residents.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 211.10(d) Resident care policies.</p> <p>28 Pa. Code: 201.18 (b) (1) (e) (1) Management.</p> <p>28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of observations and resident and staff interviews it was determined that the facility failed to provide Activity of Daily Living (ADL) assistance for three of five of residents (R4, R5, and R6).</p> <p>The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated that a BIMS (Brief Interview of Mental Status) is a brief screener that aids in detecting cognitive impairment. Scores from a BIMS assessment suggests the following distributions:</p> <p>13 - 15: cognitively intact</p> <p>8 - 12: moderately impaired</p> <p>0 - 7: severe impairment</p> <p>Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE].</p> <p>Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 5/13/25, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), muscle wasting, and aftercare after surgical amputation. Review of Section C: Cognitive Patterns revealed Resident R4 to have a BIMS score of 00. Review of previous assessments in the prior year revealed the following:</p> <p>04/01/25: BIMS of 15</p> <p>03/20/25: BIMS of 15</p> <p>12/05/24: BIMS of 15</p> <p>09/04/24: BIMS of 15</p> <p>06/04/24: BIMS of 15</p> <p>During an interview on 7/8/25, at 1:40 p.m. Resident R4 stated that the aides do not help her, that she needs a mechanical lift due to amputations of both legs, and she waits hours to get help. Resident R4 stated she regularly waits 1-2 hours for assistance. The other day, I had moved my bowels and told her (nurse aide), and she just left out.</p> <p>Review of the clinical record indicated Resident R5 was admitted to the facility on [DATE].</p> <p>Review of the MDS dated [DATE], included diagnoses of diabetes, peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and acquired absence of leg above the knee. Review of Section C: Cognitive Patterns revealed Resident R5 to have a BIMS score of 12.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/8/25, at 1:52 p.m. Resident R5 stated that call lights are not always answered timely, and that she has waited 2-3 hours. Resident R5 confirmed that she has had to wait an extended amount of time in a soiled brief for incontinence care.</p> <p>Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE].</p> <p>Review of the facility diagnosis list included chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), osteomyelitis (inflammation of bone or bone marrow, usually due to infection), and muscle weakness.</p> <p>Review of a BIMS assessment completed on 7/3/25, revealed Resident R6 to have a BIMS score of 14.</p> <p>During an interview on 7/8/25, at 1:59 p.m. Resident R6 stated, There is never enough people. They left me to sit in my own shit for five hours. I kept asking for help, they kept saying they would come back. Nobody comes when you put on the light for hours.</p> <p>During an interview on 7/9/25, at approximately 1:20 p.m. the Director of Nursing confirmed the facility failed to provide ADL assistance for three of five of residents.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and documents, clinical record review, and staff interview, it was determined that the facility failed to provide adequate supervision to prevent falls for two of four residents (Resident R1 and R2).</p> <p>Review of the facility policy, Fall Management dated 1/2/24, indicated if risks are identified, preventative measures will be put in place and care planned. All falls will be reviewed and investigated.</p> <p>Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE].</p> <p>Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 4/10/25, included diagnoses of atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat) and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Section C: Cognitive Patterns indicated Resident R1 had severe cognitive impairment. Review of Section GG: Functional Abilities indicated Resident R1 utilized a walker and a manual wheelchair.</p> <p>Review of Resident R1's plan of care for Risk for falling related to weakness dated 11/22/24, indicated to Out of bed to standard wheelchair with pressure redistribution cushion, bilateral elevating leg rests, rear anti-tippers, and anti-roll back system.</p> <p>Review of a progress note dated 6/14/25, at 5:33 p.m. indicated, CNA (nurse aide) stated she was pushing resident back to his room and slammed his feed down grabbed the railing on the wall causing him to fall fwd (forward) to the floor. CNA came to alert LPN (licensed practical nurse) who was in another resident's room assisting CNA with care. I approached resident and he was lying on his back with a small injury to his forehead.</p> <p>Review of a progress note dated 6/14/25, at 9:44 p.m. indicated, RNS (Registered Nurse Supervisor) called back to unit after resident had fallen from his wheelchair. Small laceration to mid forehead. Does not need sutures. MD notified.</p> <p>Review of a progress note dated 6/15/25, at 9:30 p.m. indicated, RN assessed head injury from fall on 6/14. Abrasion noted on mid forehead with small bum. Bump is tender to touch.</p> <p>Review of an employee statement dated 6/14/25, written by Nurse Aide (NA) Employee E3) stated, [Resident R1] asked staff me (NA Employee E3) to push him down the hall. As I was pushing him he abruptly slammed his feet down and leaned forward grabbing the rail yelling about him and roommate having their meals brought to room. [Resident R1] was still demanding staff bring a meal to his room while on floor. [Resident R1] has small abrasion in middle forehead. Staff assisted nurse with getting resident up.</p> <p>Review of an IDT (Inter-disciplinary team) note dated 6/16/25, at 9:42 a.m. indicated, Root Cause: Poor safety awareness related to dementia diagnosis. The preventative action/interventions were listed:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>OT (Occupational therapy) screen on 6/17.</p> <p>Fall Prevention program.</p> <p>Leg rests to wheelchair if resident does not self-propel.</p> <p>During an interview on 7/8/25, at approximately 2:15 p.m. the Nursing Home Administrator (NHA) confirmed that leg rests are always to be used when a resident is being pushed in a wheelchair and confirmed that the root cause was the failure of the facility staff to utilize leg rests.</p> <p>Review of the clinical record indicated Resident R2 was readmitted to the facility on [DATE].</p> <p>Review of the MDS dated [DATE], included diagnoses of debility, syncope (fainting or passing out) and collapse, and sequela (consequence of a previous disease or injury) of a fall. Review of Section GG: Functional Abilities indicated Resident R2 was not assessed by facility staff for Chair/bed-to-chair performance - the ability to transfer to and from a bed to a chair (or wheelchair). Review of the Section GG Supportive Documentation Tool dated 6/19/25, indicated Chair/bed-to-chair performance was not assessed due to Not attempted due to medical condition or safety concerns.</p> <p>During an interview on 7/8/25, at 12:32 p.m. Occupational Therapy Employee E4 stated that Resident R2 was not assessed for a chair to bed transfer due to Resident R2's requiring a mechanical lift to be safely transferred, which disallows the assessment and disallows staff from transferring without the use of a mechanical lift until the resident has been fully assessed by therapy services.</p> <p>Review of Resident R2's baseline plan of care for developed on 6/17/25, included the approaches of:</p> <ul style="list-style-type: none"> -Minimize potential risk factors to falls/injury. -Assist with transfers as needed. -Resident will receive necessary assistance for activities of daily living. <p>Further review of Resident R2's baseline care plan failed to include information related to the need for a mechanical lift for transfers.</p> <p>Review of a physician's order dated 6/17/25, discontinued 6/18/25, indicated Resident R2 required a mechanical lift for transfers. No further orders were present after 6/18/25, to indicate appropriate transfer status. As of 7/8/25, Resident R2 does not have a physician's order for transfer status.</p> <p>Review of a progress note dated 6/24/25, at 5:00 a.m. indicated, Assigned CNA notified this nurse that resident requested to sit in his wheelchair, and he slid out of the wheelchair as CNA was assisting him. Upon observation, resident was sitting next to his bed on this buttocks with both legs extended out in front of him Resident was leaning against the locked wheelchair with a towel in the seat. Resident states he in fact did slide out of the wheelchair while CNA was assisting him, denies experienced any pain related to fall or hitting his head.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of an employee statement dated 6/24/25, written by NA Employee E5 indicated, At 5:00 a.m. the resident wanted to sit in the wheelchair from the upon sitting in the wheelchair he slip from the chair and I lower him on the floor. I immediately called the Nurse on the sceam (scene).</p> <p>Review of a progress note dated 6/24/25, at 11:31 a.m. indicated, Root Cause: Towel on wheelchair causing resident to slide. The preventative action/interventions were listed:</p> <p>Continue with therapy as ordered</p> <p>Fall prevention program.</p> <p>During an interview on 7/8/25, at approximately 2:15 p.m. the NHA the nurse aide should not have transferred Resident R2 without a mechanical lift and confirmed that the root cause was the failure of the facility staff to a mechanical lift.</p> <p>During an interview on 7/9/25, at approximately 1:20 p.m. the Director of Nursing confirmed the facility failed to provide adequate supervision to prevent falls for two of four residents.</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 a review of observations and staff interviews, it was determined that the facility failed to ensure the dish machine was in proper working order in the Main Kitchen.</p> <p>Findings include:</p> <p>During an observation on 7/8/25, of the noon meal, it was noted that all the residents received their meals in Styrofoam containers and cups.</p> <p>During an observation on 7/8/25, of the Main Kitchen it was noted that the drainage sink of the dishwasher had standing water in it.</p> <p>During an interview on 7/8/25, at 1:10 p.m. Dietary Employee E1 confirmed that the dishwasher had been inoperable since Saturday morning (7/5/25), and that on Saturday and Sunday (7/5/25, 7/6/25), dietary employees had been washing dishes by hand.</p> <p>During an interview on 7/8/25, at 1:12 p.m. Dietary Manager confirmed she was not aware that the dishwasher was inoperable until the morning of 7/7/25, and she directed staff to use Styrofoam containers and cups. At this time, Dietary Manager Employee E2 confirmed that the facility administration was aware of the dishwasher was not working. Dietary Manager Employee E2 confirmed the sink portion of the dish machine was not draining and also displayed a loose piece under the sink that connected to the disposal, that she stated was also not operable.</p> <p>During an interview on 7/8/25, at 1:19 p.m. the Nursing Home Administrator was asked about the status of the inoperable dish machine, and he stated that he was unaware it was broken again, as it had been recently fixed.</p> <p>During an interview on 7/8/25, at 1:37 p.m. the Nursing Home Administrator confirmed that he educated staff on how to clean and maintain the disposal portion of the dish machine, and it was operable again.</p> <p>During an interview on 7/8/25, at approximately 2:15 p.m. the Nursing Home Administrator confirmed the facility failed to ensure the dish machine was in proper working order in the Main Kitchen.</p>		