STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395732	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Care Center	5701 Phillips Avenue Pittsburgh, PA 15217

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 develop and implement discharge planning processes that focused on residents discharge goals for one out of three discharged residents sampled (Resident R1).Findings Include: Review of facility policy Transfer or Discharge, Preparing a Resident for, dated 9/5/25, previously reviewed 9/25/24, indicated residents will be prepared in advance for discharge. When a resident is scheduled for transfer or discharge, the business office will notify nursing services of the transfer or discharge so that appropriate procedures can be implemented. A post-discharge plan is developed for each resident prior to his or her transfer or discharge. The plan will be reviewed with the resident, and/or his or her family, at least twenty-four (24) hours before the resident's discharge or transfer from the facility. Nursing services is responsible for:- obtaining orders for discharge or transfer, as well as recommended discharge services and equipment;- preparing the discharge summary and post-discharge plan;- preparing the medications to be discharged with the resident (as permitted by law);- providing the resident or representative (sponsor) with required documents (i.e., discharge summary and plan);- completing discharge note in the medical record. Review of facility policy Transfer or Discharge Documentation, dated 9/5/25, previously reviewed 9/25/24, indicated when a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider. When a resident is transferred or discharged from the facility, the followingInformation will be documented in the medical record:- The basis for the transfer or discharge;- That an appropriate notice was provided to the resident and/or legal representative;- The date and time of the transfer or discharge;- The new location of the resident;- A summary of the resident's overall medical, physical, and mental condition;- Disposition of personal effects;- Disposition of medications;- The signature of the person recording the data in the medical record.Should a resident be transferred or discharged for any reason, the following information will communicated to the receiving facility or provider:- The basis for transfer or discharge;- Contact information of the practioner responsible for the care of the residents;- Resident representative information including contact information;- Advance directive information;- All special instructions or precautions for ongoing care, as appropriate;- Comprehensive care plan goals; and- All other necessary information, including a copy of the residents discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care. A review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019 indicated that a Brief Interview for Mental Status (BIMS, a screening test that aides in detecting cognitive impairment). The BIMS total score suggests the following distributions:13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 7/31/25, indicated diagnoses cerebral infarction (a stroke, happens when a blood clot or broken vessel prevents blood from getting to the brain), Moyamoya disease (rare, progressive cerebrovascular condition characterized by the narrowing of arteries at the base of the brain, which reduces blood flow) , and diabetes mellitus (group of diseases that affects how your body uses blood sugar (glucose), leading to high blood sugar levels and potential health complications). The Cognitive Patterns Section C0500, Brief Interview for Mental Status (BIMS) revealed that Resident R1 was cognitively intact with a score of 15. The Participation in Assessment and Goal Setting Section Q0130, Resident's Overall Goal for Discharge indicated a 1: Discharge to the Community; Section Q0400, Discharge Plan: Is active discharge planning already occurring for the resident to return to the community?, was coded a 1, indicating yes. Review of Resident R1's clinical progress note date 7/27/25, revealed that he/she would like to be transferred to another facility stating that he/she is familiar with the facility and would like to go tomorrow. Further review of clinical progress notes on 7/31/25, 8/7/25, and 8/14/25, indicated Discharge Plan (location/with who and services needed): home with paid caregiver. Review of Resident R1 comprehensive care plan, initiated 7/28/25, failed to reveal any information related to discharge planning or goals of care to return to the community. Review of Resident R1's physician progress note date 8/18/25, for service date 8/14/25, revealed that goal for him/her to return home with caregivers pending therapy progress and ongoing evaluation by IDT (interdisciplinary team). Further review of physician progress note dated 8/28/25, for service date 8/21/25, revealed that he/she told physician he/she will be going home Saturday and does not