

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395745	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Rose Meadows Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 Skyline Drive Pittsburgh, PA 15227	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 review of facility documents, clinical records, and staff interview, it was determined that the facility failed to implement procedures to ensure availability of prescribed medications for three of six residents (Residents R5, R66, R102). Findings include: Review of the clinical record indicated Resident R5 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs dated 9/25/25, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat). Review of a physician's orders dated 9/19/25, indicated Resident R5 was to receive gabapentin (a medication that can be used to treat neuropathy) 1200 mg (milligrams) three times per day. Review of a physician's orders dated 9/19/25, indicated Resident R5 was to receive omeprazole (a medication to reduce stomach acid) 20 mg daily. Review of a physician's orders dated 9/20/25, indicated Resident R5 was to receive a combination medication of lisinopril (medication to lower blood pressure) 20 mg and hydrochlorothiazide (medication to reduce fluid in the body) 12.5 mg daily. Review of a physician's orders dated 9/20/25, indicated Resident R5 was to receive duloxetine (a medication that can be used to treat depression or neuropathy) 30 mg daily. Review of a physician's orders dated 9/20/25, indicated Resident R5 was to receive apixaban (a medication to prevent blood clots) 30 mg daily. Review of a physician's orders dated 9/20/25, indicated Resident R5 was to receive carvedilol (a medication that can be used to treat high blood pressure) 30 mg daily. Review of a progress note dated 9/18/25, at 8:52 p.m. indicated Resident R5 was oriented to the facility. Review of Resident R5's Medication Administration Record (MAR) for September 2025, indicated: 9/19/25: Gabapentin, hour of sleep dose documented as 9 (9 is code for order Other/See Nurse Notes). Review of the associated progress note dated 9/20/25, at 12:08 a.m. indicated, pending delivery. 9/20/25: Gabapentin, morning dose documented as 9. Review of the associated progress note dated 9/20/25, at 10:28 a.m. indicated, pending delivery. 9/20/25: Gabapentin, afternoon dose documented as 9. Review of the associated progress note dated 9/20/25, at 3:12 p.m. indicated, pending delivery. 9/20/25: Omeprazole, early morning dose documented as 9. Review of the associated progress note dated 9/20/25, at 6:29 a.m. indicated, pending pharmacy delivery. 9/20/25: Lisinopril/Hydrochlorothiazide, morning dose documented as 9. Review of the associated progress note dated 9/20/25, at 10:28 a.m. indicated, CRNP aware, awaiting delivery from RX, new admit. 9/20/25: Duloxetine, morning dose documented as 9. Review of the associated progress note dated 9/20/25, at 10:28 a.m. indicated, CRNP aware, awaiting delivery from RX, new admit. 9/20/25: Apixaban, morning dose documented as 9. Review of the associated progress note dated 9/20/25, at 10:28 a.m. indicated, CRNP aware, awaiting delivery from RX, new admit. 9/20/25: Carvedilol, morning dose documented as 9. Review of the associated progress note dated 9/20/25, at 10:28 a.m. indicated, CRNP aware, awaiting delivery from RX, new admit. Review of the facility provided inventory for the automated medication dispensing machine included gabapentin, omeprazole, lisinopril, hydrochlorothiazide, duloxetine, apixaban, and carvedilol. Review of the clinical record (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 395745	If continuation sheet Page 1 of 6

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated Resident R66 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of high blood pressure and diabetes. Review of a physician's orders dated 10/30/25, and reordered 10/31/25, indicated Resident R66 was to receive insulin aspart (an injectable medication to treat high blood sugar) 12 units four times a day (9:00 a.m., 1:00 p.m., 5:15 p.m., and 9:00 p.m.). Review of a progress note dated 10/30/25, at 7:44 p.m. indicated Resident R66 arrived at the facility at 1:45 p.m. on 10/30/25. Review of Resident R66's MAR for October 2025, indicated: 10/30/25: Insulin aspart, 9:00 p.m. dose documented as 9. Review of the associated progress note dated 10/30/25, at 10:06 p.m. indicated, pending delivery. Review of the facility provided inventory for the automated medication dispensing machine included insulin aspart. Review of the clinical record indicated Resident R102 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of atrial fibrillation and anxiety disorder. Review of a physician's orders dated 10/24/25, indicated Resident R102 was to receive buspirone (a medication to treat depression and anxiety) twice daily. Review of a physician's orders dated 10/24/25, indicated Resident R102 was to receive apixaban twice daily. Review of a progress note dated 10/24/25, at 2:30 p.m. indicated Resident R102 arrived at the facility at 2:15 p.m. on 10/24/25. Review of Resident R102's MAR for October 2025, indicated: 10/24/25: buspirone, hour of sleep dose documented as 5. Review of the associated progress note dated 10/25/25, at 12:21 a.m. indicated, awaiting medications, CRNP aware. 10/24/25: apixaban, hour of sleep dose documented as 5 (5 is code for order Hold/See Nurse Note). Review of the associated progress note dated 10/25/25, at 12:22 a.m. indicated, awaiting medications, CRNP aware. Review of the facility provided inventory for the automated medication dispensing machine included apixaban and buspirone. During an interview on 12/3/25, at 5:10 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to implement procedures to ensure availability of prescribed medications for three of six residents. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to assess, document, and notify physicians of decreased Capillary Blood Glucose (CBG) levels for one of five residents reviewed (Resident R38). Findings include: The Centers for Disease Control define diabetes as Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 milligrams per deciliter (mg/dL). If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias, and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable level of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours, or a blood glucose greater than 180 mg/dL one to two hours after eating. If you have hyperglycemia and it is untreated for long periods of time, you can damage your nerves, blood vessels, tissues, and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage, and non-healing wounds. Review of the facility policy Notification of Changes in Resident Condition and Treatment Changes reviewed 4/17/25, indicates the medical practitioner is promptly notified of significant changes in condition, and the medical record must reflect the notification, response, and interventions implemented to address the resident's condition. Review of the clinical record revealed Resident R38 was admitted to the facility on [DATE] with diagnoses that included diabetes, atherosclerotic heart disease (the buildup of fats and cholesterol substances in and on the artery walls), and hyperlipidemia (having too many fats, like cholesterol and triglycerides in your blood). Review of the Minimum Data Set (MDS- a mandated assessment of a resident's abilities and care needs) dated 9/24/25, indicated diagnoses remain current. Review of Resident R38's physician orders revealed the following orders: -On 7/3/25, Apidra SoloStar (a fast-acting insulin that starts to work about 15 minutes after injection, peaks about 1 hour, keeps working for 2-4 hours) administer before meals (8 am, 12 pm, 4 pm). If >340, notify the physician. -On 10/2/25, the CBG was noted as 342, no recheck documented. -On 10/7/25, the CBG was noted as 353, no recheck documented. -On 11/16/25, the CBG was noted as 384, no recheck documented. -On 11/17/25, the CBG was noted as 406, no recheck documented. Review of Resident R38's eMAR (computerized charting) and clinical progress notes indicated the resident was not assessed for hypoglycemia, the blood glucose was not monitored for effectiveness of treatment, and the physician was not notified of abnormal results on the above listed dates. During an interview on 12/3/25, at 5:10 p.m. the Director of Nursing confirmed that the facility failed to notify the doctor of a change in condition and failed to document an assessment or interventions used related to abnormal blood glucose levels for Resident R38. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.29 (d) Resident Rights. 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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure that residents received trauma-informed care to eliminate or mitigate triggers for residents with the diagnosis of post-traumatic stress disorder (PTSD - a mental and behavioral disorder that develops related to a terrifying event) for one of two residents reviewed (Resident R37). Findings include: Review of the facility policy, Trauma Informed Care dated 4/17/25, indicated that Each resident will be screened for a history of trauma upon admission. If trauma is identified, triggers of past trauma will be discussed and identified during the assessment process. Review of the clinical record indicated Resident R37 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 11/22/25, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), anxiety, and PTSD. Review of the facility diagnosis list indicated that the diagnosis of PTSD was added on 7/25/25. Review of Resident R37's care plan for [Resident R37] has a diagnosis of PTSD not initiated until 11/25/25, included one intervention of Encourage slow / deep breathing exercise, reassuring conversation with pleasant topics. During an interview on 12/3/25, at approximately 5:10 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to ensure that residents received trauma-informed care to eliminate or mitigate triggers for residents with the diagnosis of post-traumatic stress disorder for one of two residents reviewed. 28 Pa Code 201.24(e)(4) admission Policy. 28 Pa Code 211.12(a)(d)(3)(5) Nursing Services. 28 Pa. Code 211.16(a) Social Services.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, documents, clinical records, and staff interviews, it was determined that the facility failed to ensure that residents were free from significant medication errors for one of five residents (Resident R66). Findings include: Review of facility policy Medication Administration dated 4/17/25, indicated that medications are administered only as prescribed by the provider. Review of Resident R66's admission record indicated he was admitted to the facility on [DATE]. Review of Resident R66's Minimum Data Set (MDS - mandated assessment of a resident's abilities and care needs) dated 11/6/25, included diagnoses of type 2 diabetes (disease where the body either doesn't make enough insulin or doesn't use it properly) and encephalopathy (disease that alters brain function, causing altered mental state). Review of a physician's order dated 10/31/25, indicated for Resident R66 to receive 12 units of insulin aspart subcutaneously four times a day for blood sugars <140. Review of Resident R66's medication audit report from 11/1/25, through 11/30/25 revealed the following related to the administration of insulin aspart: 11/3/25: 9:00 p.m. dose administered with blood sugar of 110. 11/4/25: 11:45 a.m. dose administered with blood sugar of 70. 11/13/25: 7:45 a.m. dose administered with blood sugar of 125; 5:15 p.m. dose administered with blood sugar of 139; and 9:00 p.m. dose administered with blood sugar of 110. 11/22/25: 5:15 p.m. dose administered with blood sugar of 138 and 9:00 p.m. dose administered with blood sugar of 138. 11/23/25: 7:45 a.m. dose administered with blood sugar of 127. 11/2/25: 9:00 p.m. dose administered with blood sugar of 90. During an interview on 12/3/25, at approximately 5:00 p.m. the Director of Nursing confirmed that the orders for insulin aspart were specifically administered outside of the parameters set in the physician order. During an interview on 12/3/25, at approximately 5:10 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure that residents were free from significant medication errors for one of five residents. 28 Pa Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.10(c) Resident care policies. 28 Pa Code 211.12(d)(1)(3)(5) Nursing Services.		

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure that the resident and/or their representative received written notice of the facility bed-hold policy at the time of transfer for two of four residents reviewed for hospitalization (Resident R1 and R4). Findings Include: Review of federal regulation S483.15(d) Notice of Bed-Hold Policy, indicated, facilities must provide written information about these policies to residents prior to and upon transfer for such absences. This information must be provided to all facility residents, regardless of their payment source. These provisions require facilities to issue two notices related to bed-hold policies. The first notice could be given well in advance of any transfer, i.e., information provided in the admission packet. Reissuance of the first notice would be required if the bed-hold policy under the State plan or the facility's policy were to change. The second notice must be provided to the resident, and if applicable the resident's representative, at the time of transfer, or in cases of emergency transfer, within 24 hours. It is expected that facilities will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. The notice must provide information to the resident that explains the duration of bed-hold, if any, and the reserve bed payment policy. It should also address permitting the return of residents to the next available bed. Review of facility Bed Hold Policy dated 4/17/25, indicated, Prior to transfer and at the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specified the duration of the bed-hold policy and addresses information explaining the return of the residents to the most available bed. Review of the clinical record indicated Resident R1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident R1's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 11/29/25, included diagnoses of dementia (a group of symptoms that affects memory, thinking and interfere with daily life) and metabolic encephalopathy (alteration in consciousness caused by a chemical imbalance affecting the brain). Review of Section C: Cognitive Patterns indicated severe cognitive impairment. Review of a progress note dated 7/18/25, at 4:50 a.m. indicated that Resident R1 was ordered to be sent to the hospital. Further review of Resident R1's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the Resident or Resident Representative upon transfer. Review of a progress note dated 8/21/25, at 6:28 p.m. indicated that Resident R1 was ordered to be sent to the hospital. Further review of Resident R1's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the Resident or Resident Representative upon transfer. Review of a progress note dated 9/23/25, at 8:38 p.m. indicated that Resident R1 was ordered to be sent to the hospital. Further review of Resident R1's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the Resident or Resident Representative upon transfer. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's MDS dated [DATE], included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and high blood pressure. Review of Section C: Cognitive Patterns indicated Resident R4 had severe cognitive impairment. Review of a progress note dated 10/6/25, at 2:08 a.m. indicated Resident R4 was ordered to be sent to the hospital. Further review of Resident R4's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the Resident or Resident Representative upon transfer. During an interview on 12/3/25, at approximately 5:10 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to ensure that the resident and/or their representative received written notice of the facility bed-hold policy at the time of transfer for two of four residents reviewed for hospitalization. 28 Pa. Code 201.14(a) Responsibility of licensee		