STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395851	A. Building B. Wing	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehab & Nursing Ctr Greater Pittsburgh	890 Weatherwood Lane Greensburg, PA 15601

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31343 Based on review of facility policy, clinical records, documentation provided by the facility, facility investigation, resident interview, and staff interviews, it was determined that the facility failed to ensure that a resident was free from neglect by failing to provide adequate assistance and interventions to prevent fall with injury, which resulted in actual harm as evidenced by a subarachnoid hemorrhage, six staples to the left side of the scalp, and a C4 (fourth cervical vertebra) fracture which required use of a cervical collar to be worn at all times for one of three residents (Resident R1). Findings include: Review of the facility policy Abuse, Neglect, Misappropriation Prevention Program last reviewed on 1/16/25, indicated that the residents of the facility have a right to be free from abuse, neglect, exploitation and misappropriation of property. The facility will develop and implement policies to prevent and identify such concerns. Review of the facility policy Identifying Neglect last reviewed on 1/16/25, indicated that neglect is the failure of the facility to provide goods and services to a resident that are necessary to avoid or may result in physical harm - is identified as neglect. The facility is aware or should have been aware of goods or services that a resident requires but the facility fails to provide them and this has resulted in (or may result in) actual physical harm, pain, mental anguish or emotional distress. Review of the facility policy Safe Patient/Resident Handling Policy and Procedure, last reviewed on 1/16/25, indicated that staff are trained to utilize safe resident handling equipment and moving techniques to decrease the number of injuries to them and to the residents. The requirements include avoiding unassisted handling of residents and/or identifying potential high risk residents to avoid potential injuries. Review of the facility policy Bed Safety and Bed Rails last reviewed on 1/16/25, indicated that consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement regarding previous sleeping habits and environment. The resident assessment determines the use of bed rails and is prohibited unless the criteria for use is met including the residents medical diagnosis, size and weight and existence of delirium. (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 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/22/25, at 12:45 p.m., the Director of Nursing indicated that the resident must have a Brief Interview of Mental Status (BIMs) level of at least a 9 to be considered for use of siderails. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses which included anemia, gastrointestinal bleed, diabetes, a stroke, sacroilitis(inflammation of the pelvic joint), anxiety, difficulty walking, abnormal posture, and Stage 5 kidney disease, the resident refuses dialysis and will return home with Hospice. A Minimum Data Set (MDS - a periodic assessment of resident care needs) dated 3/12/25, indicated the diagnoses remained current, Section GG 0115 Functional Limitation/Range of Motion identified Resident R1 having bilateral upper extremity impairments. Section GG 0170 Mobility identified Resident R1 as partial/ moderate assist (which required one staff that does less than half the effort) for bed mobility. Additionally, Resident R1's Brief Interview of Mental Status was 15. This indicated cognition was intact. Review of Resident R1's Resident Evaluation dated 3/12/25, indicated the use of bed rails. Review of Resident R1's plan of care dated 2/25/25, indicated Resident R1 was at risk for falls due to impaired balance/poor coordination and to minimize risk for falls or injuries related to falls Resident R1 was to be encouraged to change positions slowly and use assistive devices as needed and staff were to provide assistance to transfer and ambulate as needed. Resident R1 was also identified as having an Activities of Daily Living (ADL) deficit related to physical limitations and as to receive necessary assistance to meet her ADL needs with use of bedrails. Review of the clinical record indicated that on 3/21/25, Resident R1 began having loose dark stools and dark emesis, which then prompted lab work resulting in a hemoglobin level of 6.5 (normal is 13.8-17.2) requiring a blood transfusion. Resident R1 was sent to the hospital and admitted from 3/22/25, through 3/26/25, with anemia. Review of the clinical record indicated that on 3/27/25, Resident R1 had a nosebleed and on 3/31/25, she again began having dark stools that tested positive for blood. Lab work was drawn again resulting in a Hemoglobin level of 6.6 then 5.5. Resident R1 was to be sent out for another blood transfusion. Review of the clinical record indicated that on 4/1/25, at 1:15 p.m., Resident R1 went to the hospital and had a blood transfusion and returned to the facility on [DATE], at 11:30 p.m. Review of an incident report dated 4/1/25, at 11:40 p.m., indicated that Resident R1 was being provided incontinence care by Nurse Aide (NA) Employee E1. Resident R1 had loose stools and had not been changed at the hospital. NA Employee E1 turned Resident R1 away from her and then took hands off the resident and reached away to get cleansing spray from the nightstand and NA Employee E1 stated she heard a thud, and the resident had rolled out of bed causing a head laceration, resulting in the subarachnoid hemorrhage and C4 fracture. Bed rails were not on the bed at the time of the incident. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the statement that was attached to the investigation undated but signed by NA Employee E1 stated that I rolled Resident R1 right side to left side several times to remove linens, blankets and sheets from her bed and in doing that I went from left side to right side several times. Resident R1 asked me to change her brief since it had not been done at the hospital all day. I opened the brief and she was saturated with bowel. I wiped and sprayed the front then put her on her side and wiped the back, took the brief off and liquid bowel sprayed across the sheet. Now I had no wipes left so I put Resident R1 on her back, went to the bathroom to get new pack of wipes then put Resident R1 on her side and turned to get spray from stand. I heard thud, Resident R1 rolled out of bed. During an attempted phone interview, on 4/22/25, at 11:48 a.m., NA Employee E1 was not available for comment. During an interview on 4/22/25, at 1:07 p.m., NA Employees E2 and E3, indicated that while providing incontinence care, the kardex is used and if siderails are in place and the resident is an assist of one, then they may use siderails if the resident is able to hold on. If no siderails are on and the resident is identified as requiring one assist, then always turn them towards you and go on each side or get a second staff person to help. During an interview on 4/22/25, at 1:17 p.m., NA Employee E4 stated that she will utilize the siderail if in place or turn the resident towards her to avoid the possibility of a fall. During an interview on 4/22/25, at 12:45 p.m., the DON confirmed that Resident R1 did not have siderails on her bed when the fall occurred. During an interview on 4/22/25, at 2:15 p.m., the Nursing Home Administrator and the Director of Nursing confirmed NA Employee E1 rolled Resident R1 away to provide care then turned away from Resident R1 during care resulting in neglect by not providing adequate supervision and assistance causing a fall out of bed, which resulted in actual harm for Resident R1 resulting in a subarachnoid hemorrhage, six sutures to the scalp, and a C4 fracture. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 201.29(a)(c)(d)(j) Resident rights. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3) Nursing services.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31343 Based on review of facility policy, clinical records, facility documentation, and staff interviews, it was determined that the facility failed to provide adequate assistance and interventions to prevent fall with injury, that resulted in actual harm causing a subarachnoid hemorrhage, six sutures to the scalp, and a C4 (fourth cervical vertebrae) fracture for one of three residents (Resident R1) Findings include: Review of the facility policy Safe Patient/Resident Handling Policy and Procedure, last reviewed on 1/16/25, indicated that staff are trained to utilize safe resident handling equipment and moving techniques to decrease the number of injuries to them and to the residents. The requirements include avoiding unassisted handling of residents and/or identifying potential high risk residents to avoid potential injuries. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses which included anemia, gastrointestinal bleed, diabetes, a stroke, sacroilitis(inflammation of the pelvic joint), anxiety, difficulty walking, abnormal posture, and Stage 5 kidney disease, the resident refuses dialysis and will return home with Hospice. A Minimum Data Set (MDS - a periodic assessment of resident care needs) dated 3/12/25, indicated the diagnoses remained current, Section GG 0115 Functional Limitation/Range of Motion identified Resident R1 having bilateral upper extremity impairments. Section GG 0170 Mobility identified Resident R1 as partial/ moderate assist (which required one staff that does less than half the effort) for bed mobility. Additionally, Resident R1's BIMS was 15. This indicated cognition was intact. Review of Resident R1's Resident Evaluation dated 3/12/25, indicated the use of bed rails. Review of Resident R1's plan of care dated 2/25/25, indicated Resident R1 was at risk for falls due to impaired balance/poor coordination and to minimize risk for falls or injuries related to falls Resident R1 was to be encouraged to change positions slowly and use assistive devices as needed and staff were to provide assistance to transfer and ambulate as needed. Resident R1 was also identified as having an ADL (assistance of daily living) deficit related to physical limitations and as to receive necessary assistance to meet her ADL needs with use of bedrails. Review of an incident report dated 4/1/25, at 11:40 p.m., indicated that Resident R1 was being provided incontinence care by Nurse Aide (NA) Employee E1. Resident R1 had loose stools and had not been changed at the hospital. NA Employee E1 turned Resident R1 away from her and then took hands off the resident and reached away to get cleansing spray from the nightstand; NA Employee E1 stated she heard a thud, and the resident had rolled out of bed resulting in the subarachnoid hemorrhage, scalp laceration, and C4 fracture. Bed rails were not on the bed a the time of the incident. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the statement that was attached to the investigation undated but signed by NA Employee E1 stated that I rolled Resident R1 to the right side to left side several times to remove linens, blankets and sheets from her bed and in doing that I went from left side to right side several times. Resident R1 asked me to change her brief since it had not been done at the hospital all day. I opened the brief and she was saturated with bowel. I wiped and sprayed the front then put her on her side and wiped the back, took the brief off and liquid bowel sprayed across the sheet. Now I had no wipes left so I put Resident R1 on her back, went to the bathroom to get new pack of wipes then put Resident R1 on her side and turned to get spray from stand. I heard a thud, Resident R1 rolled out of bed. During an attempted phone interview, on 4/22/25, at 11:48 a.m., NA Employee E1 was not available for comment. During an interview on 4/22/25, at 1:07 p.m., NA Employees E2 and E3, indicated that while providing incontinence care, the kardex is used and if siderails are in place and the resident is an assist of one, then they may use siderails if the resident is able to hold on. If no siderails are on and the resident is identified as requiring one assist, then always turn them towards you and go on each side or get a second staff person to help. During an interview on 4/22/25, at 1:17 p.m., NA Employee E4 stated that she will utilize the siderail if in place or turn the resident towards her to avoid the possibility of a fall. During an interview on 4/22/25, at 12:45 p.m., the DON confirmed that Resident R1 did not have siderails on her bed when the fall occurred. During an interview on 4/22/25, at 2:15 p.m., the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide adequate assistance and interventions to prevent fall with that resulted in actual harm causing a subarachnoid hemorrhage, six sutures to the scalp, and a C4 fracture for Resident R1. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 201.29(a)(c)(d)(j) Resident rights.