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	05/28/2026

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** 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 of a scalp laceration, brain bleed and hospital admission to reverse anticoagulation for one of three residents (Resident R1). Findings Include: Review of the facility policy Abuse, Neglect, Misappropriation Prevention Program last reviewed on 1/16/26, 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 1/16/26, 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 1/16/26, 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 admission record indicated that Resident R1 was admitted to the facility on [DATE], and readmitted [DATE], with diagnoses of muscle weakness, spinal stenosis, and depression. Review of Resident R1's physician order dated 7/12/25, indicated to administer 2.5 milligram (mg) Eliquis (blood thinning medication), one tablet, by mouth, two times a day. Review of Resident R1's physician order dated 7/15/25, revealed the resident requires a minimum of an assist of two persons for transfers. Review of Resident R1's Fall Risk Evaluation dated 1/3/26, indicated a score of 17 - high risk. Review of Resident R1's care plan dated 1/5/26, revealed the plan of care has been updated to reflect patient/caregiver education for staff assistance has been increased to assist of two persons with bed mobility as therapy has reported to staff, she tends to make quick movements increasing her risk for falls. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/14/26, indicated diagnoses were current. Section GG - Functional Abilities - Question GG0170 indicated the resident was coded at a 03 partial/moderate assistance for the ability to roll from lying on back to left and right side, and return to lying. Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. Review of Resident R1's clinical record nursing progress note dated 5/2/26, at 3:30 p.m., indicated revealed the writer was called to the resident's room and observed the resident on the floor next to the bed. Laceration noted to the left forehead and hematoma noted to the center forehead. The resident was bleeding from the laceration to her left side of her for head. The doctor was notified and orders were received to transport resident to the hospital for additional evaluation and treatment. The resident's family was notified. Review of facility provided report dated (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

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	05/28/2026

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	5/2/26, indicated at approximately 3:30 p.m. a Registered Nurse was called to the Resident R1's room and observed the resident on the floor next to her bed. A laceration was noted to the left side of forehead and a hematoma noted to center. Laceration was bleeding, pressure applied. Physician and family were notified of fall with head injury and a new order to transfer the resident to hospital was obtained. Resident was admitted with brain bleed. The nurse aide reported he rolled her onto her right side (away from caregiver), with her left leg over her right, and she was holding onto the bed as he tucked the sheet under her when he went to move onto the other side of the bed the resident started to fall out of bed and he could not prevent the fall. Nurse Aide provided this level of care independently when the resident required an assistance level of two. Review of Resident R1's clinical record nursing progress note dated 5/2/26, revealed the resident was being admitted to the Intensive Care Unit (ICU) for an acute subarachnoid bleed, and the resident's head laceration were sutured. Resident received anticoagulation reversal. Review of Nurse Aide, Employee E1's witness statement dated 5/2/26, revealed NA, Employee E1 was in process of changing Resident R1's brief and noticed her sheet needed changed. A brief was put under the resident and NA, Employee E1 rolled her on her right side (away from caregiver). NA, Employee E1 went to tuck the draw sheet and fitted sheet under the resident while she was on her side. The resident started to roll off the bed as the nurse aide tried to reach and roll her onto her back, but the resident rolled off the bed. The resident's head was bleeding. Review of Licensed Practical Nurse (LPN), Employee E2's witness statement dated 5/2/26, revealed the resident fell out of bed while getting changed. LPN, Employee E2 was in an other resident's room when a nurse aide notified her the supervisor needed her for an emergency. When LPN, Employee E2 entered into Resident R1's room the RN, Supervisor was holding pressure to the resident's head. Resident was lying on her back on the floor bedside her bed close to the door. LPN, Employee E2 took over holding pressure while the RN, Supervisor notified a doctor and family, and prepared to send resident to hospital. The nurse aide stated the resident rolled out of bed while he was changing her. Review of Resident R1's Kardex dated 5/3/26, revealed the resident requires an assist of two persons for bed mobility. Review of Resident R1's clinical record nursing progress note dated 5/5/26, revealed during interdisciplinary team meeting held on 5/4/26, review of current fall on 5/2/26, interventions, and care plan completed. On 5/2/26 at approximately 3:30 p.m., staff were called to the resident's room. The registered nurse observed resident on the floor next to her bed. A laceration was noted to the left side of forehead and a hematoma noted to the center. Laceration was bleeding, pressure applied, vital signs stable. Resident was noted with baseline confusion. Resident was transferred to hospital and was admitted with a brain bleed. Resident weighs only 143 pounds and per last MDS on 4/15/26, and is partial/mod assist with mobility rolling left to right. Statement obtained from nurse aide who was assisting resident while in bed, resident was changed for an incontinent episode, during the change the nurse aide noticed the sheet was wet and also required changed. The nurse aide reported he rolled her onto her right side, with her left leg over her right, and she was holding onto the bed as he had tucked the sheet under her when he went to move onto the other side of the bed the resident started to fall out of bed and he could not prevent the fall. Review of Resident R1's Hospital After Visit Summary dated 5/8/26, revealed the resident was admitted to the hospital for a subarachnoid hemorrhage and facial laceration. It was indicated for the resident to pause taking 2.5 mg Eliquis until doctor or other care provider tells you to start again. During a phone interview on 5/28/26, at 9:49 a.m. NA, Employee E1 stated he entered into Resident R1's room on 5/2/26, to conduct rounds and placed the resident's bed up to waist height. As NA, Employee E1 went to roll Resident R1, he didn't realize how far she was on side of bed. The nurse aide had his hand on her, to try to make sure she didn't fall, however as he went to the corner of the bed she started to roll the opposite direction, and started falling head first and her head hit the foot of the bed. Once she was rolled off the bed frame, we noticed blood coming from her head. NA, Employee E1 confirmed he failed to use the correct level of assistance for Resident R1's bed mobility and rolled the resident away from himself. During an interview on 5/28/26, at 10:20 a.m. LPN, Employee E2 stated staff can check a (continued on next page)

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	05/28/2026

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	resident's transfer status and bed mobility in their plan of care. It was indicated staff should always roll residents towards them and not away to prevent them from falling off bed. LPN, Employee E2 confirmed Resident R1 was on blood thinners at time of incident and there was a good bit of blood. Interviews with direct care staff to include Registered Nurses (RN). Licensed Practical Nurses (LPN), and Nurse Aides (NA), indicated that when providing care to check the Kardex for appropriate assistance levels and to always roll the residents toward your person. Only this staff had received re-education on proper bed mobility and assistance and Kardex usage. During an interview on 5/28/26, at 10:28 a.m. Resident R1 was observed lying in bed with a scabbed area located on the resident's left side of her head. During an interview on 5/28/26, at 10:34 a.m. Director of Therapy revealed Resident R1 was a moderate assist of two person at the time on the fall that occurred on 5/2/26. The Director of Therapy confirmed therapy staff is considered direct care staff, and confirmed the therapy department has not been educated since Resident R1's incident. Interview on 5/28/26, at 12:03 p.m. with the Nursing Home Administrator confirmed the facility failed to make certain Resident R1 was free from neglect by failing to provide the correct level of assistance and interventions to prevent a fall with injury resulting in actual harm of a laceration, head injury and admission to the hospital for anticoagulation reversal 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) Resident Rights28 Pa. Code 211.10(c)(d) Resident Care Policies.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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	05/28/2026

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 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** Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision and assistance for bed mobility to prevent accidents which resulted in actual harm of a head bleed for one of three residents (Resident R1).Findings Include: Review of facility Falls and Fall Risk, Managing policy dated 1/15/26, indicated that based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Review of the admission record indicated that Resident R1 was admitted to the facility on [DATE], and readmitted [DATE], with diagnoses of muscle weakness, spinal stenosis, and depression. Review of Resident R1's physician order dated 7/12/25, indicated to administer 2.5 milligram (mg) Eliquis (blood thinning medication), one tablet, by mouth, two times a day. Review of Resident R1's physician order dated 7/15/25, revealed the resident requires a minimum of an assist of two persons for transfers. Review of Resident R1's Fall Risk Evaluation dated 1/3/26, indicated a score of 17 - high risk. Review of Resident R1's care plan dated 1/5/26, revealed the plan of care has been updated to reflect patient/caregiver education for staff assistance has been increased to assist of two persons with bed mobility as therapy has reported to staff, she tends to make quick movements increasing her risk for falls. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/14/26, indicated diagnoses were current. Section GG - Functional Abilities - Question GG0170 indicated the resident was coded at a 03 partial/moderate assistance for the ability to roll from lying on back to left and right side, and return to lying. Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. Review of Resident R1's clinical record nursing progress note dated 5/2/26, at 3:30 p.m., indicated revealed the writer was called to the resident's room and observed the resident on the floor next to the bed. Laceration noted to the left forehead and hematoma noted to the center forehead. The resident was bleeding from the laceration to her left side of her for head. The doctor was notified and orders were received to transport resident to the hospital for additional evaluation and treatment. The resident's family was notified. Review of facility provided report dated 5/2/26, indicated at approximately 3:30 p.m. a Registered Nurse was called to the Resident R1's room and observed the resident on the floor next to her bed. A laceration was noted to the left side of forehead and a hematoma noted to center. Laceration was bleeding, pressure applied. Physician and family were notified of fall with head injury and a new order to transfer the resident to hospital was obtained. Resident was admitted with brain bleed. The nurse aide reported he rolled her onto her right side (away from caregiver), with her left leg over her right, and she was holding onto the bed as he tucked the sheet under her when he went to move onto the other side of the bed the resident started to fall out of bed and he could not prevent the fall. Review of Resident R1's clinical record nursing progress note dated 5/2/26, revealed the resident was being admitte3d to the Intensive Care Unit (ICU) for an acute subarachnoid bleed, and the resident's head laceration were sutured. Resident received anticoagulation reversal. Review of Nurse Aide, Employee E1's witness statement dated 5/2/26, revealed NA, Employee E1 was in process of changing Resident R1's brief and noticed her sheet needed changed. A brief was put under the resident and NA, Employee E1 rolled her on her right side (away from caregiver). NA, Employee E1 went to tuck the draw sheet and fitted sheet under the resident while she was on her side. The resident started to roll off the bed as the nurse aide tried to reach and roll her onto her back, but the resident rolled off the bed. The resident's head was bleeding. Review of Licensed Practical Nurse (LPN), Employee E2's witness statement dated 5/2/26, revealed the resident fell out of bed while getting changed. LPN, Employee E2 was in an other resident's room when a nurse aide notified her the supervisor needed her for an emergency. When LPN, Employee E2 (continued on next page)

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	05/28/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	entered into Resident R1's room the RN, Supervisor was holding pressure to the resident's head. Resident was lying on her back on the floor bedside her bed close to the door. LPN, Employee E2 took over holding pressure while the RN, Supervisor notified a doctor and family, and prepared to send resident to hospital. The nurse aide stated the resident rolled out of bed while he was changing her. Review of Resident R1's Kardex dated 5/3/26, revealed the resident requires an assist of two persons for bed mobility. Review of Resident R1's clinical record nursing progress note dated 5/5/26, revealed during interdisciplinary team meeting held on 5/4/26, review of current fall on 5/2/26, interventions, and care plan completed. On 5/2/26 at approximately 3:30 p.m., staff were called to the resident's room. The registered nurse observed resident on the floor next to her bed. A laceration was noted to the left side of forehead and a hematoma noted to the center. Laceration was bleeding, pressure applied, vital signs stable. Resident was noted with baseline confusion. Resident was transferred to hospital and was admitted with a brain bleed. Resident weighs only 143 pounds and per last MDS on 4/15/26, and is partial/mod assist with mobility rolling left to right. Statement obtained from nurse aide who was assisting resident while in bed, resident was changed for an incontinent episode, during the change the nurse aide noticed the sheet was wet and also required changed. The nurse aide reported he rolled her onto her right side, with her left leg over her right, and she was holding onto the bed as he had tucked the sheet under her when he went to move onto the other side of the bed the resident started to fall out of bed and he could not prevent the fall. Review of Resident R1's Hospital After Visit Summary dated 5/8/26, revealed the resident was admitted to the hospital for a subarachnoid hemorrhage and facial laceration. It was indicated for the resident to pause taking 2.5 mg Eliquis until doctor or other care provider tells you to start again. During a phone interview on 5/28/26, at 9:49 a.m. NA, Employee E1 stated he entered into Resident R1's room on 5/2/26, to conduct rounds and placed the resident's bed up to waist height. As NA, Employee E1 went to roll Resident R1, he didn't realize how far she was on side of bed. The nurse aide had his hand on her, to try to make sure she didn't fall, however as he went to the corner of the bed she started to roll the opposite direction, and started falling head first and her head hit the foot of the bed. Once she was rolled off the bed frame, we noticed blood coming from her head. NA, Employee E1 confirmed he failed to use the correct level of assistance for Resident R1's bed mobility and rolled the resident away from himself. During an interview on 5/28/26, at 10:20 a.m. LPN, Employee E2 stated staff can check a resident's transfer status and bed mobility in their plan of care. It was indicated staff should always roll residents towards them and not away to prevent them from falling off bed. LPN, Employee E2 confirmed Resident R1 was on blood thinners at time of incident and there was a good bit of blood. Interviews with direct care staff to include Registered Nurses (RN). Licensed Practical Nurses (LPN), and Nurse Aides (NA), indicated that when providing care to always roll the residents toward your person. Only this staff had received re-education on proper bed mobility and assistance. During an interview on 5/28/26, at 10:28 a.m. Resident R1 was observed lying in bed with a scabbed area located on the resident's left side of her head. During an interview on 5/28/26, at 10:34 a.m. Director of Therapy revealed Resident R1 was a moderate assist of two person at the time on the fall that occurred on 5/2/26. The Director of Therapy confirmed therapy staff is considered direct care staff, and confirmed the therapy department has not been educated since Resident R1's incident. Interview on 5/28/26, at 12:03 p.m. with the Nursing Home Administrator confirmed the facility failed to make certain each resident received adequate supervision and assistance for bed mobility to prevent accidents which resulted in actual harm of a head bleed for one of three residents (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) Resident Rights28 Pa. Code 211.10(c)(d) Resident Care Policies.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.