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	11/26/2025

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 0575 Level of Harm - Potential for minimal harm Residents Affected - Some	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observations and a staff interview, it was determined the facility failed to post contact information, Adult Protective Services (APS), Medicaid Fraud Unit, and a statement the resident may file a complaint with the State Agency as required, in the building. Findings include: The facility must post, in a form and manner accessible and understandable to residents, resident representatives; a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit. Observations conducted on 11/25/25, at approximately 11:30 a.m., on the nursing units, revealed the facility did not have the required elements (agency name, address, email address, and phone number) of Adult Protective Services (APS), Medicaid Fraud Unit, and a statement the residents may file a complaint with the State Agency posted or accessible to residents or resident representatives. During rounds and an interview with the Nursing Home Administrator (NHA) on 11/26/25, at 8:15 a.m., the NHA confirmed the facility failed to post required information for Adult Protective Services (APS), Medicaid Fraud Unit, and a statement the residents may file a complaint with the State Agency as required, in the building. 28 Pa. Code: 201. 14(a)Responsibility of licensee. 28 Pa. Code: 201.18(e) Management

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on review of facility policy, observations, and resident and staff interviews, it was determined that the facility failed to make accessible grievance boxes to residents in three of three locations, 300-lounge, main dining room, and front lobby. Findings include: A review of the facility policy Grievances/Complaints, Filing reviewed 1/16/25, grievances and/or complaints may be submitted orally or in writing and may be filed anonymously. The Centers for Medicare & Medicaid Services (CMS) does not specify exact height requirements for grievance boxes in skilled nursing facilities. However, CMS mandates that grievance procedures be accessible to all residents, including those with disabilities, in compliance with the Americans with Disabilities Act (ADA). In Pennsylvania, the Department of Health incorporates by reference the federal requirements outlined in 42 CFR Part 483, Subpart B, which pertains to long-term care facilities. These regulations emphasize the importance of accessibility but do not provide additional specifications regarding grievance box placement. To ensure accessibility, the ADA Standards for Accessible Design recommend that operable parts, such as slots on grievance boxes, be mounted between 15 and 48 inches above the floor. This range accommodates individuals using wheelchairs and ensures usability for a broad range of residents. During a resident group interview, on 11/24/25 at approximately 1:30 p.m., when asked if they felt they could anonymously file a grievance in the grievance boxes, consensus from the group was no. Residents stated, they are too high to reach, they are not made for people in wheelchairs, and you have to ask someone to help you, so we just ask the staff to do it for us. During rounds on 11/26/25, at 8:15 a.m. the Nursing Home Administrator and surveyor measured the height of the grievance boxes in the 300-lounge, height was 53 inches, main dining room, height was 52 inches, and front lobby, height was 51 inches. Access to the boxes in both the 300 lounge and front lobby were blocked by a table. During an interview on 11/26/25, at 8:30 a.m. the Nursing Home Administrator confirmed the facility failed to make accessible grievance boxes to residents in three of three locations, 300-lounge, main dining room, and front lobby. 28 PA Code: 201.18(e)(4) Management. 28 PA Code: 201.29(a)(b)(c) Resident rights.

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F 0600 Level of Harm - Minimal harm or potential for 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, facility documentation and staff interview, it was determined that the facility failed to protect a resident from neglect and verbal abuse for one of three residents (Resident R114). Findings include:Review of facility policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 1/16/25, indicated residents have a right to be free from abuse, neglect, misappropriation of resident property and exploitation. Review of the Resident Assessment Instrument 3.0 User's Manual, effective October 2024, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. Review of the clinical record indicated Resident R114 was admitted to the facility on [DATE]. Review of Resident R114's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 9/24/25, indicated diagnoses of kidney disease, Chron's disease and diabetes. Question C0500 BIMS Summary Score indicated the resident scored a 15, cognitively intact. Question GG0170 Mobility indicated the resident was coded moderate assist (requiring assist of one staff). Review of a facility grievance document dated 9/24/25, indicated the following: Resident R114 reported that she had not been given an attitude by the nurse aide(NA) (identified as NA Employee E3) when she asked for help to go to the bathroom, but the call bell was not responded to until after she had to take herself to the bathroom as she could not wait any longer and NA Employee E3 responded, it looks like you're already doing it and walked out huffing and puffing.Review of a statement obtained on 9/23/25, from NA Employee E4 indicated that NA Employee E3 had gone in to check on Resident R114 and was told that Employee E3 had slammed Resident R114's door and had been bullying residents all day and swearing and stating that she does not have time for the resident's crap. NA Employee E4 stated that NA Employee E3 is thrown out of resident rooms, and they don't want her in their rooms. Review of a statement obtained on 9/23/25, from NA Employee E5 indicated that when the nurse aides were coming into work, NA Employee E3 was swearing and upset due to staffing being changed. Later when she and NA Employee E3 entered a resident's room, NA Employee E3 stated can you shut the fuck up so he (the resident) can finish talking so he can shut the fuck up and NA Employee E5 stated NA Employee E3 had an attitude and leaving her call bells ringing and did not help pass or pick up trays.During an interview on 11/24/25, at 11:19 a.m., the Director of Nursing confirmed that she did not identify the grievance and statements as potential neglect/ abuse and felt the information was enough of an investigation and took it no further. Confirmed the facility failed to protect one of three residents (Resident R114) from neglect and abuse. 28 Pa. Code: 201.14(a) Responsibility of licensee28 Pa. Code: 201.18(b)(1) Management.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, information provided by the facility, clinical records and staff interview, it was determined the facility failed to promptly conduct a thorough investigation to rule out abuse and implement corrective action and submit the results of the completed investigation to the State Survey Agency within five working days of the incident as evidenced by one of three residents reviewed (Resident R114).Findings include:Review of facility policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 1/16/25, indicated residents have a right to be free from abuse, neglect, misappropriation of resident property and exploitation. The policy indicated that the facility will identify and investigate all possible incidents of abuse, neglect, mistreatment or misappropriation of resident property within times frames required by federal requirements.Review of the Resident Assessment Instrument 3.0 User's Manual, effective October 2024, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. Review of the clinical record indicated Resident R114 was admitted to the facility on [DATE]. Review of Resident R114's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 9/24/25, indicated diagnoses of kidney disease, Chron's disease and diabetes. Question C0500 BIMS Summary Score indicated the resident scored a 15, cognitively intact. Question GG0170 Mobility indicated the resident was coded moderate assist (requiring assist of one staff). Review of a facility grievance document dated 9/24/25, indicated the following: Resident R114 reported that she had not been given an attitude by the nurse aide(NA) (identified as NA Employee E3) when she asked for help to go to the bathroom, but the call bell was not responded to until after she had to take herself to the bathroom as she could not wait any longer and NA Employee E3 responded, it looks like you're already doing it and walked out huffing and puffing.Review of a statement obtained on 9/23/25, from NA Employee E4 indicated that NA Employee E3 had gone in to check on Resident R114 and was told that Employee E3 had slammed Resident R114's door and had been bullying residents all day and swearing and stating that she does not have time for the resident's crap. NA Employee E4 stated that NA Employee E3 is thrown out of resident rooms, and they don't want her in their rooms. Review of a statement obtained on 9/23/25, from NA Employee E5 indicated that when the nurse aides were coming into work, NA Employee E3 was swearing and upset due to staffing being changed. Later when she and NA Employee E3 entered a resident's room, NA Employee E3 stated can you shut the f*** up so he (the resident) can finish talking so he can shut the f*** up and NA Employee E5 stated NA Employee E3 had an attitude and leaving her call bells ringing and did not help pass or pick up trays.During an interview on 11/24/25, at 11:19 a.m., the Director of Nursing confirmed that she did not identify the grievance and statements as potential neglect/ abuse and felt the information was enough of an investigation and took it no further. Confirmed the facility failed to identify, thoroughly investigate to rule out abuse and implement corrective action and submit the results of the completed investigation to the State Survey Agency within five working days of the incident as evidenced by one of three residents reviewed (Resident R114). 28 Pa. Code 201.14 (c) Responsibility of licensee.28 Pa. Code 201.18 (b)(1) Management.28 Pa. Code 201.29 (a) Resident rights.28 Pa. Code 211.10(d) Resident care policies.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**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 three of seven residents reviewed (Residents R6, R86, and R100).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 levels 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 ' s 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 Management of Hypoglycemia reviewed 1/16/25, indicated the facility provided guidelines for managing hypoglycemia secondary to insulin therapy, or oral hypoglycemic agents. The facility classification/implement protocol of hypoglycemia is as follows:- Level 1: Blood glucose is less than 70mg/dl but greater than 54 mg/dl. Protocol: give oral form of glucose, notify provider immediately, remain with resident, recheck blood glucose in 15 minutes, provide resident meal or snack.- Level 2: Blood glucose is less than 54 mg/dl. Protocol: administer glucagon (rapid form of glucose), notify provider immediately, remain with the resident, place resident in a comfortable and safe place, monitor vital signs, and recheck blood glucose in 15 minutes.- Level 3: Altered mental and/or physical status requiring assistance for treatment of hypoglycemia. Protocol: call 911, administer glucagon or intravenous (IV) 50% glucose, if IV access. Review of the facility policy Change in Resident's Condition or Status reviewed 1/16/25, indicated the nurse will notify the resident's attending physician or physician on call when there has been a need to alter the resident's medical treatment significantly. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Review of the clinical record revealed Resident R6 was admitted to the facility on [DATE], with diagnoses that included congestive heart failure (progressive heart disease that affects pumping action of the heart muscles), diabetes, and high blood pressure. Review of Resident R6 physician's order revealed the following orders:- On 10/3/25, Hypoglycemic protocol - for blood sugar less than 80 if symptomatic or blood sugar less than 70 with or without symptoms present (1) Administer approximately 15 grams of glucose by mouth or carbohydrates found in any of the following: 1/2 cup juice, 1/2 cup applesauce, one cup milk, one tube glucose gel, three glucose tablets AND (2) Wait 15 minutes AND (3) Recheck blood sugar levels, if level still below target give another 15 grams of glucose or meal/snack within one hour. Review of the clinical record, and electronic Medication Administration Record (eMAR) revealed the CBG's were as follows: - On 10/4/25, at 7:01 p.m. CBG was noted to be 49.- On 10/17/25, at 8:04 a.m. CBG was noted to be 65.- On 11/22/25, at 4:21 p.m. CBG was noted to be 61. Review of Resident R6 eMAR 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 order was not followed for hypoglycemic protocol. Review of Resident R6 care plan revised on 11/18/25, failed to reveal interventions for diabetes management, including

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, observations and staff interviews, it was determined that the facility failed to provide appropriate respiratory care and maintain oxygen equipment for four of five sampled residents (Residents R1, R2, R53, and R98).Findings include: Review of the facility policy Departmental (Respiratory Therapy) - Prevention of Infection last reviewed on 1/16/25, indicated that considerations related to oxygen administration include change the oxygen cannula and tubing every seven days or as needed. Keep the oxygen and tubing used as needed in a plastic bag when not in use. Considerations related to medication nebulizers/continuous aerosol include store the circuit in a plastic bag, marked with date and resident's name, between uses. Discard the administration set up every seven days. Review of Resident R1's admission record indicated she was originally admitted on [DATE]. Review of Resident R1's Minimum Data Set (MDS- a periodic assessment of care needs) dated 10/1/25, indicated the diagnoses of pneumonia (lung infection), coronary artery disease (CAD restriction of blood flow to the heart), and heart failure (heart doesn't pump blood as well as it should). Review of Resident R1's current physician orders, indicated resident is on 2 liters per minute of oxygen. Interview and rounds on 11/25/25, at 11:10 a.m. with Licensed Practical Nurse (LPN) Employee E6, Resident R1 was observed in bed and using oxygen. The tubing failed to be labeled as required. Review of Resident R2's admission record indicated she was originally admitted on [DATE]. Review of Resident R2's MDS dated [DATE], indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), heart failure (heart doesn't pump blood as well as it should), and hypertension (high blood pressure). Review of Resident R2's current physician orders, indicated resident is on 2 liters per minute of oxygen and wash filter weekly, label with date. Interview and rounds on 11/25/25, at 11:15 a.m. with Licensed Practical Nurse (LPN) Employee E6, Resident R2 was observed sitting in a chair and using oxygen. The tubing failed to be labeled with an identifiable date. Review of Resident R53's admission record indicated she was originally admitted on [DATE]. Review of Resident R53's MDS dated [DATE], indicated the diagnoses of respiratory failure (not enough oxygen in the body), heart failure (heart doesn't pump blood as well as it should), and hypertension (high blood pressure). Review of Resident R53's current physician orders, indicated resident is on 2 liters per minute of oxygen, change oxygen and nebulizer tubing and wash filter weekly, label with date and initials. Interview and rounds on 11/25/25, at 11:20 a.m. with Licensed Practical Nurse (LPN) Employee E6, Resident R53 was observed sitting in a chair and using oxygen. The tubing failed to be labeled with an identifiable date. Review of Resident R98's admission record indicated she was originally admitted on [DATE]. Review of Resident R98's MDS dated [DATE], indicated the diagnoses of chronic obstructive pulmonary disease (COPD irreversible lung and airway damage), bipolar disorder (extreme mood swings), and diabetes mellitus (high blood sugar). Review of Resident R98's current physician orders, indicated resident is on 2 liters per minute of oxygen and wash filter weekly, label with date. Interview and rounds on 11/25/25, at 11:30 a.m. with Licensed Practical Nurse (LPN) Employee E6, Resident R98 was observed in bed and using oxygen. The tubing failed to be labeled with an identifiable date. During an interview on 11/25/25, at 11:40 a.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to provide appropriate respiratory care and maintain oxygen equipment for four of five sampled residents (Residents R1, R2, R53, and R98). 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and staff interviews, it was determined that the facility failed to ensure that current and accurate nurse staffing information was posted in the facility at the beginning of each shift. Findings include: Observation conducted on 11/24/25, at approximately 9:00 a.m., revealed that nurse staffing information was posted in the main lobby on the reception desk. At that time, the nurse staffing information had the date of (11/7/25), resident census, and the staffing hours did not accurately reflect the current total number of hours worked for licensed and unlicensed nursing staff directly responsible for resident care per shift for the current date. During an interview on 11/24/25, at 9:05 a.m., Employee E2 receptionist stated that the posting for staffing isn't up to date. During an interview with the Nursing Home Administrator (NHA) on 11/24/25, at approximately 9:50 a.m., the NHA confirmed the facility failed to post the required current facility information for staffing hours and the census for 11/24/25. 201.18(b)(3) Management.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility policy, observations and staff interview, it was determined that the facility failed to properly store food products in the walk-in cooler and freezer which created the potential for cross contamination (Main Kitchen). Findings include: Review of facility policy Food Receiving and Storage dated 1/16/25, indicated foods shall be received and stored in a manner that complies with safe food handling practices. All foods stored in the refrigerator or freezer are covered, labeled and dated. Refrigerated foods are stored in a way which allows for adequate air circulation around food containers. During an observation of the main kitchen on 11/24/25, at 9:50 a.m., the following was observed: Walk in cooler:-one jar of grape jelly was opened undated. Freezer - boxes of multiple types of food items stored to ceiling on top shelves of whole freezer and under fans. During an interview on 11/24/25, at 10:00 a.m., Dietary Manager Employee E1 confirmed that the facility failed to properly store food products and maintain sanitary conditions which created the potential for food borne illness and cross contamination in the Main Kitchen. 28 Pa. Code: 201. 14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(3) Management.