STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396066	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitehall Borough Skilled Nursing and Rehab Center	505 Weyman Road Pittsburgh, PA 15236

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43725 Based on clinical record review, observation and resident and staff interviews, it was revealed that the facility failed to prevent involuntary seclusion for two of 10 residents reviewed (Resident R1, and R2). Findings include: Review of the facility policy Abuse Prohibition reviewed 1/30/24, indicated the facility prohibits abuse, mistreatment, neglect, misappropriation of resident property, and exploitation of all residents. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Involuntary seclusion is defined as separation of a resident from other residents or from their room or confinement to their room against the resident's will or the will of the resident's legal representative. Neglect is defined as the failure, indifference, or disregard to provide care, comfort, safety, goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of the facility policy, Treatment: Considerate and Respectful reviewed 1/30/24, indicated the facility provides patients the right to a quality of life that supports independent expression, decision making, and respect. Staff will show respect when communicating with, caring for, or talking about patients. Review of the Resident Rights Under Federal Law reviewed 1/30/24, indicated the resident has the right to a dignified existence. The resident has the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safety. The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, indicated that a BIMS (Brief Interview of Mental Status) is a brief screener that aids in detecting cognitive impairment. Scores from a BIMS assessment suggests the following distributions: 13 - 15: cognitively intact 8 - 12: moderately impaired (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: 396066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Whitehall Borough Skilled Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 Weyman Road Pittsburgh, PA 15236	

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	0 - 7: severe impairment Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses that included dementia (loss of memory, language, problem-solving, and other thinking abilities that interferes with daily life), anxiety, and depression. Review of the Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 5/22/24, indicated the diagnoses remain current. Further review of the MDS, Section C: Cognitive Patterns; Question C0500 BIMS Summary Score indicated 99 (resident scored four or more zeros or gave nonsensical answers). Section GG: Functional Abilities and Goals; Question GG0170 Mobility D: Sit to Stand indicated Resident R1 required substantial/maximal assistance (helper does more than half the effort, lifts or holds trunk or limbs). During an observation on 6/13/24, at 10:22 a.m. a voice was heard yelling help me, please help me coming from behind a locked closed door leading to the main hallway labeled Dining Room. During an observation on 6/13/24, at 10:25 a.m. Resident R1 and Resident R2 were observed in the locked Memory Care Unit sitting in wheelchairs in the dining room by themselves at a far table in the corner by the locked exit door from which the yelling was heard from the other side. Staff were not in sight of the residents. The dining room was accessed through the resident television room which contained eight other residents. Resident R1 was sitting in her wheelchair facing the locked door, with her locked wheelchair pushed all the way in under the table, preventing her from moving around. Resident R2 was sitting in a wheelchair at the same table facing the entrance door, she was backed up against the locked exit door, with the table pushed up against her, preventing her from moving. An empty tall back wheelchair was observed pushed beside the table, preventing exit from the sides of the table, the fourth side of the table was up against a wall. Resident R1 indicated she needed her brief changed. The table contained one small juice box with a straw in front of Resident R1. Review of the progress notes revealed the following: - On 6/8/24, at 10:12 a.m. resident OOB (out of bed) to chair by the dining room. - On 5/17/24, at 2:39 p.m. pt (patient) sitting in dining area (assessment completed in dining room by provider). - On 5/13/24, at 12:00 a.m. pt sitting in dining area (assessment completed in dining room by provider). - On 4/29/24, at 2:43 p.m. pt sitting in dining area (assessment completed in dining room by provider). - On 4/28/24, at 9:08 a.m. OOB to chair by the dining room at this time. Review of the care plan dated 1/12/23, indicated to encourage socialization with others and provide recreational programming, engage in activities/tasks to keep occupied, encourage/assist to reposition frequently to position of comfort, encourage participation in group activities of interest, provide supplies/materials for leisure activities as needed/requested. On 4/25/24, the care plan stated to remove patient from table if she begins hitting lower or upper extremities on table. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Whitehall Borough Skilled Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 Weyman Road Pittsburgh, PA 15236	

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE], with diagnoses that included high blood pressure, cognitive communication deficit (difficulty with any aspect of communication that is affected by disruption of thinking), and depression. Review of the MDS dated [DATE], indicated the diagnoses remain current. Further review of the MDS indicated Resident R2 ' s BIMS score was 09 indicating moderate impairment. Section GG: Functional Abilities and Goals, Question GG0170 D. Sit to Stand indicated Resident R2 required partial/moderate assistance (helper does less than half the effort). Review of the progress notes reveal the following: - On 6/5/24, at 1:35 p.m. patient presents in the dining hall. (assessment completed in dining room by provider). - On 2/2/24, at 12:00 a.m. On exam, pt seen sitting in wheelchair in dining hall. (assessment completed in dining room by provider). Review of the care plan dated 11/10/23, indicate Resident R2 was at risk for falls, to encourage/assist to reposition frequently to position of comfort, remind and assist as needed with toileting at routine times such as upon arising in AM, before/after meals, activities, therapy, and at bedtime. On 11/15/23, the care plan states to provide supplies/materials for leisure activities as needed/requested. During an interview on 6/13/24, at 10:26 a.m. Registered Nurse Employee E1 stated they were not sure why the two ladies were in the dining room by themselves, stating they usually do not work that nursing unit and are unfamiliar with the residents, but they thought that Resident R1 and R2 needed to be kept eyes on them or the residents would get up and fall. During an interview on 6/13/24, at 10:36 a.m. Unit Manager Employee E2 stated the residents yell all the time, and the empty wheelchair is there to prevent them from pulling objects closer to them like they usually do, like the garbage can. During an interview on 6/13/24, at 10:38 a.m. Nurse Aide Employee E3 stated Resident R1 and R2 are put in the dining room because they cause a disturbance when the other residents are watching television because they yell a lot, and they are fall risks. During an interview on 6/13/24, at 12:30 p.m. the Nursing Home Administrator was notified the facility failed to prevent involuntary seclusion for Residents R1 and R2. 28 Pa. Code 201.18(2) Management. 28 Pa. Code 201.29(d) Resident rights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER: Whitehall Borough Skilled Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 505 Weyman Road Pittsburgh, PA 15236	

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43725 Based on review of facility policy, clinical record review, facility documentation, and staff interview, it was determined that the facility failed to ensure two of 10 residents observed (Resident R1, and R2) were free from physical restraints by being pushed up to a table with a wheelchair blocking the side exit. Findings include: Review of the facility policy Abuse Prohibition reviewed 1/30/24, indicated the facility prohibits abuse, mistreatment, neglect, misappropriation of resident property, and exploitation of all residents. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Involuntary seclusion is defined as separation of a resident from other residents or from their room or confinement to their room against the resident's will or the will of the resident's legal representative. Neglect is defined as the failure, indifference, or disregard to provide care, comfort, safety, goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of the facility policy Restraints: Use of reviewed 1/30/24, indicated residents have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat resident's medical symptoms. Convenience is defined as the result of any action that has the effect of altering a resident's behavior such that the resident requires a lesser amount of effort or care, and is not in the resident's best interest. Physical Restraint is defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: - Is attached or adjacent to the resident's body, - Cannot be removed easily by the resident, and - Restricts the resident ' s freedom of movement or normal access to their body. Removed Easily means that the manual method, physical or mechanical device, equipment, or material can be removed intentionally by the resident in the same manner as it was applied by staff. Review of the facility policy, Treatment: Considerate and Respectful reviewed 1/30/24, indicated the facility provides patients the right to a quality of life that supports independent expression, decision making, and respect. Staff will show respect when communicating with, caring for, or talking about patients. Review of the facility policy Behavioral Health Care and Services reviewed 1/30/24, indicated residents will be provided the necessary behavioral health care and services including providing an environment and atmosphere that is conductive to mental and psychosocial well-being. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Whitehall Borough Skilled Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 Weyman Road Pittsburgh, PA 15236	

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident Rights Under Federal Law reviewed 1/30/24, indicated the resident has the right to a dignified existence. The resident has the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safety. The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, indicated that a BIMS (Brief Interview of Mental Status) is a brief screener that aids in detecting cognitive impairment. Scores from a BIMS assessment suggests the following distributions: 13 - 15: cognitively intact 8 - 12: moderately impaired 0 - 7: severe impairment Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses that included dementia (loss of memory, language, problem-solving, and other thinking abilities that interferes with daily life), anxiety, and depression. Review of the Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 5/22/24, indicated the diagnoses remain current. Further review of the MDS, Section C: Cognitive Patterns; Question C0500 BIMS Summary Score indicated 99 (resident scored four or more zeros or gave nonsensical answers). Section GG: Functional Abilities and Goals; Question GG0170 Mobility D: Sit to Stand indicated Resident R1 required substantial/maximal assistance (helper does more than half the effort, lifts or holds trunk or limbs). During an observation on 6/13/24, at 10:25 a.m. Resident R1 and Resident R2 were observed in the locked Memory Care Unit sitting in their wheelchairs in the dining room by themselves at a table in the corner by the locked exit door. The dining room is assessable through the resident television lounge room which contained eight other residents. Resident R1 was sitting in her wheelchair facing the locked door with her wheelchair pushed all the way in under the table, preventing her from moving around. Resident R2 was sitting at the same table in her wheelchair a facing the entrance door to the resident television room, she was backed up against the locked exit door, with the table pushed up against her, preventing her from moving. An empty tall back wheelchair was observed pushed beside the table, preventing exit from the sides of the table. The fourth table side was against the wall. Resident R1 indicated she needed her brief changed. The residents were unable to move the table due to both of them being pushed up to it and the wheelchair blocking the side exit. At the time of the observation, the residents could not independently move away from the table or manuver the wheelchair on command. Review of the care plan dated 1/12/23, indicated to encourage socialization with others and provide recreational programming, engage in activities/tasks to keep occupied, encourage/assist to reposition frequently to position of comfort, encourage participation in group activities of interest, provide supplies/materials for leisure activities as needed/requested, and indicated Resident R1 was at risk for falls. On 4/25/24, remove patient from table if she begins hitting lower or upper extremities on table. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Whitehall Borough Skilled Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 Weyman Road Pittsburgh, PA 15236	

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE], with diagnoses that included high blood pressure, cognitive communication deficit (difficulty with any aspect of communication that is affected by disruption of thinking), and depression. Review of the MDS dated [DATE], indicated the diagnoses remain current. Further review of the MDS indicated Resident R2 ' s BIMS score was 09 indicating moderate impairment. Section GG: Functional Abilities and Goals, Question GG0170 D. Sit to Stand indicated Resident R2 required partial/moderate assistance (helper does less than half the effort). Review of the care plan dated 11/10/23, indicate Resident R2 was at risk for falls, to encourage/assist to reposition frequently to position of comfort, remind and assist as needed with toileting at routine times such as upon arising in AM, before/after meals, activities, therapy, and at bedtime. On 11/15/23, provide supplies/materials for leisure activities as needed/requested. During an interview on 6/13/24, at 10:26 a.m. Registered Nurse Employee E1 stated they did not know why the two ladies were in the dining room by themselves, stating they usually do not work that nursing unit and are unfamiliar with the residents, but they thought that Resident R1 and R2 needed to be kept eyes on them or the residents would get up and fall. During an interview on 6/13/24, at 10:36 a.m. Unit Manager Employee E2 stated the residents are in the dining room all the time and like to drag objects closer to the table they are sitting at. During an interview on 6/13/24, at 10:38 a.m. Nurse Aide Employee E3 stated Resident R1 and R2 are put in the dining room because they cause a disturbance when the other residents are watching television because they yell a lot, and if they are not pushed against the table they try to stand up and will fall. During an interview on 6/13/24, at 12:30 p.m. the Director of Nursing stated she saw the wheelchair blocking the residents at the dining table the other day but did not think of it as a restraint. During an interview on 6/13/24, at 12:30 p.m. the Nursing Home Administrator was made aware the facility failed to prevent physical restraints of being pushed into the table and having a wheelchair blocking the table for Residents R1 and R2. 28 Pa. Code 201.18(2) Management. 28 Pa. Code 201.29(d) Resident rights.