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	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitehall Borough Post Acute	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interview, it was determined that the facility failed to provide adequate supervision to avoid injuries for one of three residents (Resident R1). Findings include:Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 7/16/25, included diagnoses of COPD, muscle weakness, and the need for aftercare following joint replacement surgery. Review of Section G: Functional Status indicated that Resident R1 required supervision for eating. Review of Resident R1's plan of care for ADL (activities of daily living)/mobility dated 7/11/25, indicated for staff to monitor for changes or decline in ability to participate in ADLs, decreased strength, increased weakness, or changes in cognition. Further review of the care plan failed to reveal documentation of the needed assistance level during meals. Review of a progress note dated 8/18/25, at 10:00 a.m. indicated, Resident lying in bed, very lethargic, slow to respond, not responding appropriately, or follow direction. not engaging in conversation, poor eye contact. alert to name and place, not alert to date. not able to recall this nurse. Resident appeared flushed, with slight body tremors, 95/46 (blood pressure)-99.2 (temperature)-72 (heart rate)-16 (respiration rate). 77% on room air, o2 (oxygen) applied at 2L (two liters) with gradual response to 90%, o2 increased to 3L with pox of 96%. Review of a nurse practitioner's note dated 8/18/25, at 11:33 a.m. indicated, Pt (patient) evaluated per request of nursing for acute hypoxia (low level of oxygen in the body tissues). Per nursing, pt was found to be sating (slang to refer to a patient's oxygen saturation level) at 77%, unsure for how long. Nurse further stated pt was confused from baseline.Review of a progress note dated 8/18/25, at 2:35 p.m. indicated that Resident R1 had slurred speech and notable hand tremors. Review of a progress note dated 8/18/25, at 3:05 p.m. indicated Resident R1 had a change in condition, shortness of breath, tired, weak, confused, or drowsy. Review of a progress note dated 8/19/25, at 1:11 p.m. indicated, This nurse was called by CNA (nurse aide) to look at pt's right front thigh that appeared to be pink in color circular shaped 15 cm x 15 cm x 0 cm: intact skin. Pt stated she spilled entire lunch tray with hot soup onto her lap.Review of a grievance filed on 8/19/25, indicated, Resident was passed her lunch tray, it was set up for her by the CNA. While eating chicken noodle soup, [Resident R1] spilled the hot soup on herself and reported to the nursing staff that she spilled the soup and burned herself. The resolution to this grievance included:-Pt cleaned up by nursing staff.-Sensitive area to inner thighs assessed by RN (registered nurse) and CRNP (certified registered nurse practitioner). CRNP ordered to keep OTA (open to air) and monitor for pain/complications.-Tremors seem to be newer onset, NP/MD (doctor of medicine) evaluating for potential cause. In the meantime, hot soups will be removed from the resident's meal trays for safety measures.-Investigation of food temps (temperatures) by [Dietary Manager]. - [Resident R1] agreeable to resolution.Review of facility-submitted information dated 9/5/25, indicated On 8/19/2025 the patient was provided her lunch tray as it was set up for her by her CNA. Patient reported to nursing staff that she had spilled her chicken noodle soup and burned herself. Area to thigh assessed by licensed nurse and CRNP. CRNP ordered area to OTA and report any further pain and or complications. After interview with nursing staff and patient - patient appears to have an onset of tremors. CRNP and MD to assess tremors and determine any interventions that may assist with tremors. Hot soups will be replaced on meal trays. The dietician and dietary manager also temped trays and determined that food and fluids were within the threshold to serve patients. Please note since 8/19/2025 patient has not had any issues and or incidents with her meal tray.During an interview on 9/5/25, at approximately 1:00 p.m. the Director of Nursing confirmed that Resident R1 had been showing symptoms of confusion, lethargy, and tremors prior to 8/19/25, with documentation that Resident R1 was below her baseline, but was not provided additional supervision when served hot soup on 8/19/25. During an interview on 9/5/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed the facility failed to provide adequate supervision to avoid injuries for one of three residents.28 Pa. Code: 201.18(e) Management.28. Pa Code: 201.29(a)(c)(d) Resident rights.