STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396067	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concordia at Rebecca Residence	3746 Cedar Ridge Road Allison Park, PA 15101

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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 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 a review of facility policies, facility forms, observations and staff interviews it was determined that the facility failed to properly date, and store food products, and verify the sanitizing temperature of the dish machine in the Main Kitchen (Main Kitchen), which created the potential for food borne illness. Findings Include: Review of the facility policy Monitoring of Cooler/Freezer Temperature last reviewed 11/1/25, indicated that all food items will be stored at least 6 inches off the ground and 18 inches from the ceiling. Refrigerated food shall be labeled dated, and monitored so that it is used by the use by date, frozen, or discarded, whichever is applicable. Review of the facility policy Dishwasher Temperature Procedure, last reviewed 11/1/25, indicated that all items cleaned in the dishwasher will be washed in water that is sufficient to sanitize any and all items. Water temperatures shall be measured and recorded prior to each meal and/or after the dishwasher has been emptied or re-filled for cleaning purposes. During an observation and interview in the Main Kitchen walk-in freezer, on 6/23/25, at 9:50 a.m. an opened box of breaded fish was on the floor of the freezer, and four bags of vegetables were not labeled with a receive date to ensure proper rotation. Food Service Director Employee E7 confirmed that the facility failed to properly store and label food in the walk-in freezer. During an observation in the Dish Room on 6/24/26, at 12:30 p.m. the facility form Dishwasher Temperature Log for June 2026, had the following occurrences where the wash and rinse temperatures were not recorded: 6/1/26: breakfast, lunch, dinner6/2/26: breakfast, lunch, dinner6/3/26: dinner6/4/26: breakfast, lunch, dinner6/5/26: breakfast, lunch, dinner6/6/26: breakfast, lunch, dinner6/7/26: breakfast, lunch, dinner6/8/26: breakfast, lunch, dinner6/9/26: lunch, dinner6/10/26: breakfast, lunch, dinner6/11/26: breakfast, dinner6/12/26: breakfast, dinner6/13/26: lunch, dinner6/14/26: breakfast, lunch, dinner6/15/26: breakfast, lunch, dinner6/16/26: lunch, dinner6/17/26: dinner6/18/26: dinner6/19/26: lunch, dinner6/20/26: lunch, dinner6/21/26: lunch, dinner6/22/26: breakfast, lunch, dinner6/23/26: dinner6/24/26: breakfast Review of the above documentation revealed 54 missed opportunities for documentation of dishwasher temperatures out of 70 meals. During an interview on 6/24/26, at 1:05 p.m. Food service Director confirmed that the facility failed to properly verify the sanitizing temperature for the dish machine which created the potential for food borne illness. 28 Pa. Code 201.14(a)Responsibility of licensee.28 Pa. Code 201.18(b)(1)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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for four of four residents sampled with facility-initiated transfers (Residents R1, R2, R65, and R82), and failed to notify the Office of the State Long-Term Care Ombudsman upon discharge for two of two resident (Residents R4, and R84). Findings include: Review of facility policy Transfer and discharge date d 11/1/25, indicated that for a transfer to another provider, for any reason the resident's comprehensive care plan goals must be provided to the receiving provider. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/27/26, indicated diagnoses of high blood pressure, heart failure (a progressive heart disease that affects pumping action of the heart muscles), and depression. Review of the clinical record indicated Resident R1 was transferred to the hospital on 6/14/26, and returned to the facility on 6/14/26. Review of the clinical record indicated Resident R1 was transferred to the hospital on 6/18/26, and returned to the facility on 6/18/26. Review of Resident R1's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS dated [DATE], indicated diagnoses of high blood pressure, difficulty swallowing, and pain in right shoulder. Review of the clinical record indicated Resident R2 was transferred to the hospital on 6/15/26, and returned to the facility on 6/18/26. Review of Resident R2's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R65 was admitted to the facility on [DATE]. Review of Resident R65's MDS dated [DATE], indicated diagnoses of muscle wasting, weakness, and (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dysphagia (difficult swallowing). Review of the clinical record indicated Resident R65 was transferred to the hospital on 5/31/26, and returned to the facility on 6/2/26. Review of the clinical record indicated Resident R65 was transferred to the hospital on 6/19/26, and returned to the facility on 6/19/26. Review of Resident R65's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R82 was admitted to the facility on [DATE]. Review of Resident R82's MDS dated [DATE], indicated diagnoses of high blood pressure, difficulty swallowing, and low back pain. Review of the clinical record indicated Resident R82 was transferred to the hospital on 4/21/26. Review of Resident R82's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals to meet the resident's specific needs at the receiving facility. During an interview on 6/24/26, a5 5:11 p.m. the Director of Nursing (DON) confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for Residents R1, R2, R65, and R82. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's MDS dated [DATE], indicated diagnoses of high blood pressure, hip fracture, and muscle wasting. Review of the clinical record indicated Resident R4 was discharged from the facility on 6/8/26. During an interview on 6/24/26, at 1:50 p.m. Social Worker Employee E8 stated that the facility does not notify the Office of the State Long-Term Care Ombudsman of any discharges from the facility as required. Review of the clinical record indicated Resident R84 was admitted to the facility on [DATE]. Review of Resident R84's MDS dated [DATE], indicated diagnoses of chronic pain, hip fracture, and muscle wasting. Review of the clinical record indicated Resident R84 was discharged from the facility on 4/23/26. During an interview on 6/24/26, at 1:50 p.m. Social Worker Employee E8 stated that the facility does not notify the Office of the State Long-Term Care Ombudsman of any discharges from the facility as (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required, therefore no notifications were sent for Resident R4, and R84. 28 Pa. Code: 201.14(a)Responsibility of licensee.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review and staff interviews, it was determined the facility failed to notify the physician of a change in condition for two of four residents (Resident R1, and R65).Findings include: Review of facility policy Resident Rights dated 6/5/26, indicated the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/27/26, indicated diagnoses of high blood pressure, heart failure (a progressive heart disease that affects pumping action of the heart muscles), and depression. Review of the clinical record indicated Resident R1 was transferred to the hospital on 6/18/26, and returned to the facility on 6/18/26. Review of Resident R1's progress notes indicated on 6/18/26, at 2:07 a.m. resident complained of pressure in bladder. Urine output zero at this time. Resident bladder scanned for urine. Spoke with resident. Foley (catheter that goes into bladder to drain urine) had no output. Told resident writer would rescan. Resident comfortable with this. Review of Resident R1's progress note indicated on 6/18/26, at 5:51 a.m. resident returned from hospital. Removed urine and new foley inserted. Resident pleasant and happy with trip to hospital. Review of Resident R1's progress note on 6/24/26, failed to include documentation of notifying the physician of a change of condition that required a transport to an acute care facility for evaluation and treatment for Resident R1 on 6/18/26. During an interview on 6/24/26, at 5:20 p.m. the Director of Nursing stated, The Registered Nurse (RN) on call was not notified to come into facility. Review of the clinical record indicated Resident R65 was admitted to the facility on [DATE]. Review of Resident R65's MDS dated [DATE], indicated diagnoses of muscle wasting, weakness, and dysphagia (difficult swallowing). Review of the clinical record indicated Resident R65 was transferred to the hospital on 5/31/26, and returned to the facility on 6/2/26. Review of Resident R65's progress notes indicated on 5/31/26, at 4:31 p.m. Patient was outside with family. Family brought him back in because they thought he was sleeping. Nurse Aide (NA) went in to put patient in bed and found him to be unresponsive and grey. Blood Pressure was 76/47, Pulse 46, Oxygen Saturate 68 percent. Sternal rub was performed and patient was moved from wheelchair to bed. He does not remember coming back in from outside or any other details. 911 was notified and son was notified. Resident was taken to acute hospital. Review of Resident R1's progress notes on 6/24/26, failed to include documentation notifying the physician of a change of condition that required a transport to an acute care facility for evaluation and treatment for Resident R65 on 5/31/26. Review of the clinical record indicated Resident R65 was transferred to the hospital on 6/19/26, and returned to the facility on 6/19/26. Review of Resident R65's progress notes indicated on 6/19/26, at 4:06 a.m. resident awake. Complained of slight pain in chest blood pressure, 192 /82 oxygen saturation 100 percent, respirations 24. Resident states pain has subsided. Resident blood pressure rechecked 205/88. Denies any pain in chest. Spoke with supervisor. Called 911. Resident awake and alert at this time. Denies any chest pain. Blood pressure 196 88. Resident left facility. Review of Resident R65's progress notes on 6/24/26, failed to include documentation notifying the physician of a change of condition that required a transport to an acute care facility for evaluation and treatment for Resident R65 on 6/19/26. During an interview on 6/25/26, at 9:28 a.m. Registered Nurse Employee E6 stated, The nurse should always notify the physician when a change of condition occurs. We can receive new orders if needed. During an interview on 6/24/26, at 5:20 the Director of Nursing confirmed that the facility failed to notify the physician of a change of condition for two of four residents (Resident R1, and R65). 28 Pa. Code 201.14(a)(c) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to develop care plans that included instructions to provide person centered care for two of eight residents (Resident R52 and R67).Findings include: Review of facility's policy Comprehensive Care Plans dated 6/5/26, indicated the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs. Review of facility policy Enhanced Barrier Precautions dated 6/5/26, indicated the facility will implement enhanced barrier precautions for the prevention of transmission of organisms. Review of admission record indicated Resident R52 was admitted to the facility on [DATE]. Review of Resident R52's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/2/26, indicated the diagnoses of muscle wasting, depression, and osteoarthritis (degeneration of the joint causing pain and stiffness). Review of Resident R52's physician orders dated 1/28/26, indicated Foley Catheter (a catheter inserted into bladder to drain urine) for neurogenic bladder (a condition where nerve damage or disease disrupts the communication between your brain, spinal cord, and bladder). Review of Resident R52's care plan failed to include a care plan with goals and interventions for residents Foley catheter and catheter care per physician's order for neurogenic bladder, and failed to include Enhanced Barrier Precautions for foley catheter. During an interview on 6/25/26, at 9:28 a.m. Registered Nurse Assessment Coordinator (RNAC) Employee E6 confirmed that the facility failed to have a person-centered care plan for Resident R52. Review of the clinical record revealed Resident R67 was admitted to the facility on [DATE]. Review of Resident R67's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/17/26, indicated diagnoses of chronic kidney disease (an inability of the kidneys to filter the blood), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and heart disease. Review of a physician order dated 6/1/26, indicated Abdominal binder every shift for hypotension (low blood pressure). Review of a physician order dated 6/17/26, indicated knee high TED hose (compression socks) to lower extremities. Remove for hygiene and skin checks. Review of Resident R67's care plan failed to include a care plan with goals and interventions for residents' abdominal binder and TED hose per physician's order for hypotension, and failed to include Enhanced Barrier Precautions for dialysis port. During an interview on 6/25/26, at 9:28 a.m. RNAC Employee E6 stated that care plans should be individualized and confirmed that the facility failed to have a person-centered care plan for Resident R67. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility documents, clinical record review, and staff interviews, it was determined that the facility failed to make certain that residents were provided appropriate treatment and care in accordance with professional standards of practice for three of ten residents (Resident R1, R49, and R65). Findings include: Review of Registered Nurse (RN), Charge Nurse Job Description, indicated that it is the RN Charge Nurse duty to complete accurate, complete, and timely assessments in order to determine resident problems so nursing care can be planned, implemented, and evaluated. Review of facility policy Fluid Restriction dated 11/1/25,inidctaed that the facility will ensure that fluid restrictions will be followed in accordance to physician's orders. Water will not be provided at bedside unless calculated into the daily total fluid restriction. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/27/26, indicated diagnoses of high blood pressure, heart failure (a progressive heart disease that affects pumping action of the heart muscles), and depression. Review of the clinical record indicated Resident R1 was transferred to the hospital on 6/18/26, and returned to the facility on 6/18/26. Review of Resident R1's progress notes, written by a Licensed Practical Nurse, indicated on 6/18/26, at 2:07 a.m. resident complained of pressure in bladder. Urine output zero at this time. Resident bladder scanned for urine. Spoke with resident. Foley (catheter that goes into bladder to drain urine) had no output. Told resident writer would rescan. Resident comfortable with this. Review of Resident R1's progress note indicated on 6/18/26, at 5:51 a.m. resident returned from hospital. Removed urine and new foley inserted. Resident pleasant and happy with trip to hospital. Review of Resident R1's progress note on 6/24/26, failed to include documentation of a Registered Nurse assessment for a change of condition that required a transport to an acute care facility for evaluation and treatment for Resident R1 on 6/18/26. During an interview on 6/24/26, at 5:20 p.m. the Director of Nursing stated, The Registered Nurse (RN) on call was not notified to come into facility and confirmed there was no RN assessment completed with Resident R1's change of condition. Review of the clinical record revealed that Resident R49 was admitted to the facility on [DATE]. Review of Resident 49's MDS dated [DATE], indicated diagnoses of high blood pressure, malnutrition, and congestive heart failure (CHF-condition in which the heart has trouble pumping blood through the body). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R49's clinical record revealed a physician's order dated 6/11/26, to provide a No Added Salt diet, regular texture, regular consistency, 1500 milliliter (ml) flid restriction = 960 ml dietary + 480 ml nursing + 60 ml at nursing discretion for CHF. During an observation on 6/23/26, at lunch time in the First Floor Dining Room, Resident R49's meal ticket indicated that she was ordered a fluid restriction. During an observation on 6/23/26, at 1:03 p.m. Resident R49 was observed in her room drinking out of a water pitcher left at her bedside. During an observation on 6/25/26, 9:29 a.m. Resident R49 was resting in bed and had a full water pitcher at her bedside. Across the room from her bed was a sign posted on the bulletin board that stated Drink Water. During an interview on 6/25/26, at 9:30 a.m. Nurse Aide (NA) Employee E10 stated that he is assigned to take care of Resident R49. When NA Employee E10 was asked if resident was on a fluid restriction, he replied I don't think so. During an interview on 6/25/26, at 9:37 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed that she was the nurse assigned to take care of Resident R49. When LPN Employee E49 was asked if resident was on a fluid restriction, she replied Not that I'm aware of. LPN Employee E49 proceeded to review Resident R49's Treatment Administration Record (TAR) , and stated No there isn't anything in her TAR about a fluid restriction. State Agency requested that LPN Employee E49 look at Resident R 49's physician ordered diet. LPN Employee E49 then confirmed that resident was order a fluid restriction, but that the order did not get transferred into the TAR, and that's how staff would have been made aware that they needed to restrict Resident R49's daily fluid intake. LPN Employee E1 confirmed that the facility failed to implement the fluid restriction as ordered. During an interview on 6/25/26, at 10:05 a.m. Physician's Assistant (PA) Employee E11 confirmed that she had ordered the fluid restriction for Resident R49, and that this was done due to She has CHF and pretty bad swelling in her legs, and that fluid restriction should have been implemented as ordered. Review of the clinical record indicated Resident R65 was admitted to the facility on [DATE]. Review of Resident R65's MDS dated [DATE], indicated diagnoses of muscle wasting, weakness, and dysphagia (difficult swallowing). Review of the clinical record indicated Resident R65 was transferred to the hospital on 5/31/26, and returned to the facility on 6/2/26. Review of Resident R65's progress notes indicated on 5/31/26, at 4:31 p.m. Patient was outside with family. Family brought him back in because they thought he was sleeping. Nurse Aide (NA) went in to put patient in bed and found him to be unresponsive and grey. Blood Pressure was 76/47, Pulse 46, Oxygen Saturate 68 percent. Sternal rub was performed and patient was moved from wheelchair to bed. He does not remember coming back in from outside or any other details. 911 was notified and son was notified. Resident was taken to acute hospital. Review of Resident R65's progress notes on 6/24/26, failed to include documentation of a Registered (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse assessment for a change of condition that required a transport to an acute care facility for evaluation and treatment for Resident R65 on 5/31/26. Review of the clinical record indicated Resident R65 was transferred to the hospital on 6/19/26, and returned to the facility on 6/19/26. Review of Resident R65's progress notes indicated on 6/19/26, at 4:06 a.m. resident awake. Complained of slight pain in chest blood pressure, 192 /82 oxygen saturation 100 percent, respirations 24. Resident states pain has subsided. Resident blood pressure rechecked 205/88. Denies any pain in chest. Spoke with supervisor. Called 911. Resident awake and alert at this time. Denies any chest pain. Blood pressure 196 88. Resident left facility. Review of Resident R65's progress notes on 6/24/26, failed to include documentation of a Registered Nurse assessment for a condition that required a transport to an acute care facility for evaluation and treatment for Resident R65 on 6/19/26. During an interview on 6/25/26, at 9:28 a.m. Registered Nurse Employee E6 stated, If a resident has a change of condition, the Registered Nurse should assess the resident, notify the physician of the findings, and document in the medical record. During an interview on 6/24/26, at 5:20 the Director of Nursing confirmed that the facility failed to have a Registered Nurse assess residents with a change of condition for two of four residents (Resident R1, and R65). 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical records and staff interview, it was determined that the facility failed to individualize care plans to address the resident specific nutrition, and hydration concerns for two of two residents (Resident R27, and R49).Findings include: Review of the facility policy Comprehensive Care Plans dated 11/1/25, indicated that facility will develop and implement a comprehensive person-centered care plan for each resident. The comprehensive care plan includes: the baseline care plan, comprehensive care plan with updates; orders, medication administration records; treatment administration records; aide documentation summary/task lists and all additional orders. Review of the clinical record revealed that Resident R27 was admitted to the facility on [DATE]. Review of Resident 27's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/30/26, indicated diagnoses of high blood pressure, malnutrition (lack of sufficient nutrients in the body), and weakness. Section K0310 indicated that resident has had weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months, and is not on a physician-prescribed weight-loss regimen. Review of Resident R27's clinical record revealed a physician's order dated 6/18/26, that stated to provide a Regular diet, regular consistency, magic cup (a nutrient dense nutrition supplement) at lunch and dinner. Review of Resident R27's clinical record revealed a physician's order dated 6/22/26, that stated to provide four ounces of Ensure Clear (a nutrient dense nutrition supplement) every morning and at bedtime Review of Resident R27's care plan last revised on 6/10/26, indicated that resident has potential for altered nutritional status related to varied intake, dysphagia (difficulty swallowing), and malnutrition, and interventions included the following: Diet/liquids/texture as ordered. Provide supplements as ordered. Review of Resident R27's care plan failed to include that she has had a significant weight loss, and did not include resident specific interventions for the physician ordered diet and supplements listed above. Review of the clinical record revealed that Resident R49 was admitted to the facility on [DATE]. Review of Resident 49's MDS dated [DATE], indicated diagnoses of high blood pressure, malnutrition, and congestive heart failure (CHF-condition in which the heart has trouble pumping blood through the body). Review of Resident R49's clinical record revealed a physician's order dated 6/11/26, to provide a No Added Salt diet, regular texture, regular consistency, 1500 milliliter (ml) flid restriction = 960 ml dietary + 480 ml nursing + 60 ml at nursing discretion for CHF. Review of Resident R49's care plan last revised on 6/10/26, indicated that resident has potential for altered nutritional status related to morbid obesity and edema (swelling caused by too much fluid trapped in the body's tissues). At risk for alteration in hydration. At risk for fluid volume overload. Interventions included the following: Diet/liquids/texture as ordered. Keep water available and within reach at bedside, Offer fluids with any interactions with resident. Review of Resident R49's care plan failed to include resident specific interventions for the physician ordered diet listed above, and actually encouraged fluid intake instead of a fluid restriction as ordered. During an interview on 6/24/26, at 2:34 p.m. Diet Technician Employee E9 confirmed that the facility failed to identify weight loss in Resident R27's care plan, and failed to individualize care plans to address the resident specific nutritional concerns for Resident R27, and R49. 28 Pa. Code 201.18(b)(1)(Management.28 Pa. Code 211.10(c) Resident care policies.28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396067	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concordia at Rebecca Residence	3746 Cedar Ridge Road Allison Park, PA 15101

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to properly store medical supplies in one of two medication rooms (First Floor), failed to ensure medication supplements were administered correctly for one of four residents (Resident R17), and failed to secure a medication cart for one of four medication carts (First Floor). Findings: Review of the facility policy Medication Storage in the Facility dated 6/5/26, indicated medications and biologicals are stored safely, securely, and properly. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock. Review of the facility policy Medication Administration dated 6/5/26, indicated medications are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice. Observe resident consumption of medication. During a medication storage room review on 6/23/26, at 10:50 a.m. the following were observed: A vial of tuberculin (medication used to detect respiratory disease) was opened and no expiration date was on the vial. During an interview on 6/23/26, at 10:54 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed the above findings and that the facility failed to properly store medical supplies in one of two medication rooms (First Floor). Review of admission record indicated Resident R17 was admitted to the facility on [DATE]. Review of Resident R17's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/27/26, indicated the diagnoses of quadriplegia (paralysis of all four limbs), muscle wasting, and dysphagia (difficult swallowing). During a review of physician order dated 3/20/26, indicated to give Juven Oral Packet (nutritional supplement) one packet every day for wound healing. During a review of physician order dated 3/21/26, indicated to give Active Liquid Protein (nutritional supplement) 30 milliliters twice a day. During a medication administration observation on 6/24/26, at 9:15 a.m. Licensed Practical Nurse (LPN) Employee E3 mixed up Resident R17's Juven and Liquid Protein in water, sat the cup on the bedside table, and left the room. LPN Employee E3 failed to watch Resident R17 drink the prescribed nutritional supplements prior to leaving the room. During an interview on 6/24/26, at 9:20 a.m. LPN Employee E3 stated, I should have watched Resident R17 drink the supplements before leaving the room to make sure he drank it, and confirmed that the facility failed to ensure that medication supplements were administered correctly, per physician orders for Resident R17. During an observation on 6/25/26, at 9:35 a.m. a medication cart was being stored behind a nurse's station and was unlocked. During an interview on 6/25/26, at 9:40 a.m. Registered Nurse Employee E2 stated, The medication cart should be locked. and confirmed that the medication cart was left unattended and unlocked behind the nurse's station. 28 Pa Code: 211.9 (a)(1) Pharmacy services. 28 Pa code: 211.12 (d) (1) (5) Nursing services.

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	396067	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concordia at Rebecca Residence	3746 Cedar Ridge Road Allison Park, PA 15101

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility documentation, and staff interviews, it was determined that the facility failed to make certain that equipment was in safe operating condition for one of two crash carts (a cart that contains supplies in the event of an emergency), (First Floor) and one of two Automated External Defibrillator (AED-a portable, electronic device designed to diagnose and treat life-threatening cardiac arrhythmias), (First Floor).Findings include: Review of the facility policy Cardiopulmonary Resuscitation (CPR) dated [DATE], indicated if a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services according to resident's advanced directives. During an observation of the facilities crash cart, located on the First Floor, on [DATE], at 11:00 a.m. revealed the following supplies to be expired: (2) bottles of saline water expired [DATE].(1) Ambu bag (a handheld manual resuscitator used to provide positive pressure ventilation) was removed from the manufacturer bag and was sitting in the bottom drawer with no expiration date available and not stored in a bag. During a review of facility provided document labeled Emergency Cart daily checklist of the facilities crash cart (First Floor) on [DATE], at 11:08 a.m. failed to reveal any evidence of monitoring of the function of the AED and checking expired supplies for the AED. During an interview on [DATE], at 11:15 a.m. Registered Nurse Employee E2 stated, I thought the AED was included on the crash cart checklist, but I guess not, and confirmed the above findings for the facilities crash cart and AED. During an interview on [DATE], at 2:45 p.m. the Director of Nursing confirmed that the facility failed to make certain that equipment was in safe operating condition for one of two crash carts, (First Floor) and one of two AED's (First Floor). 28 Pa Code: 201.14(a) Responsibility of licensee.

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	396067	A. Building B. Wing	06/25/2026

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Some	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, facility documentation and staff interview, it was determined that the facility failed to have documentation of grievances for 2026. Findings include: During review of facility grievances on 6/24/26, at approximately 11:00 a.m. 2025 grievances were documented. During additional review no 2026 grievances were documented. During an interview on 6/25/26, at 1:30 p.m. NHA confirmed that documentation of grievances for 2026 could not be located. 28 Pa. Code 201.24 (e)(2) admission policy.28 Pa. Code 201.29 (a) Resident rights.