STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39A438	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwestern Veterans Center	7060 Highland Drive Pittsburgh, PA 15206

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to accommodate the call bell needs for one of five residents (Resident R88). Findings include: Review of the clinical record indicated Resident R88 was admitted to the facility on [DATE]. Review of Resident R88's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/13/25, indicated diagnoses of hemiplegia (paralysis on one side of the body), anxiety, and constipation. During an observation on 4/21/25, at 12:18 p.m. Resident R88's call bell was observed on the floor under the resident's bed. During an interview on 4/21/25, at 12:19 p.m. Licensed Practical Nurse Employee E2 confirmed Resident R88's call bell was not accessible and unavailable for use to the resident and that the facility failed to accommodate Resident R88's call bell needs. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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 - Some Note: The nursing home is disputing this citation.	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. 50075 Based on review of facility policy, group interview, observations of resident areas and nursing units, and staff interviews it was determined that the facility failed to ensure anonymous grievance boxes are readily accessible for resident use on three of three floors (Second, Third, and Fourth Nursing Floor). Findings include: The facility Resident Rights policy dated 1/16/25, indicated that the resident has the right to make a complaint to the staff of the nursing home, or any other person, without fear of punishment or reprisal. The nursing home must address the issue promptly. During an observation on 4/21/25, at 2:30 p.m. no grievance boxes were located on the Second Nursing Floor where residents, resident representatives, or visitors could utilize, if needed. During an observation on 4/21/25, at 2:36 p.m. no grievance boxes were located on the Third Nursing Floor where residents, resident representatives, or visitors could utilize, if needed. During an observation on 4/21/25, 2:41 p.m. no grievance boxed were located on the Fourth Nursing Floor were residents, resident representatives, or visitors could utilize, if needed. During an observation on 4/21/25, at 2:45 p.m. an anonymous grievance box was observed in the lobby hall sitting on a ledge with six wheelchairs being stored in front of it. The anonymous grievance box was not readily accessible to anyone at this time. During an interview on 4/21/25, at 2:49 p.m. the Assistant Nursing Home Administrator Employee E10 confirmed that the anonymous grievance box was in the lobby hallway and that there are no other grievance boxes throughout the facility that are readily accessible to residents, resident representatives, or visitors. During an interview on 4/21/25, at 2:51 the Assistant Nursing Home Administrator Employee E10 confirmed that the anonymous grievance box in the lobby hallway was blocked by six wheelchairs and was not readily accessible. During an interview on 4/22/25, at 9:31 a.m. Social Worker, Grievance Officer, Employee E4 stated, I'm not familiar with any grievance boxes on the nursing floors. There is something down on the first floor but I'm not sure where its at. Residents usually come to me to file a grievance. During a group interview on 4/22/25, at 11: 00 a.m. three out of seven residents during a group meeting did not know where to find a grievance box in the facility, stated no grievance boxes were on the units, all you do is give your grievance to the social worker, and were unsure of how to file a grievance anonymously. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 4/22/25, at 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure anonymous grievance boxes are readily accessible for resident, resident representative, and visitor use on three of three floors (Second, Third, and Fourth Nursing Floor). 28 Pa. Code 201.18e(4)Management. 28 Pa. Code 201.29(a)Resident rights.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on a review of facility policy, Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interviews, it was determined that the facility failed to ensure that Minimum Data Set (MDS - a periodic assessment of care needs) assessments accurately reflected the resident's status for two of six residents (Residents R51 and R113). Findings include: Review of facility policy MDS 3.0 Completion, Maintenance, and Submission dated 1/16/25, indicated all disciplines shall follow the guidelines in Chapter 3 of the current RAI Manual for coding each assessment. The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated the following instructions: - Section O: Special Treatments, Procedures, and Programs - Question O0110C1, Oxygen therapy: Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item. This item may be coded if the resident places or removes their own oxygen mask, cannula. O0110C3, Intermittent: check if oxygen therapy was intermittent (i.e., not delivered continuously for at least 14 hours per day). - Section O: Special Treatments, Procedures, and Programs - Question O0110G1, Non-invasive Mechanical Ventilator: Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to support their own spontaneous respiration by providing enough pressure when the individual inhales to keep their airways open, unlike ventilators that breathe for the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes their own BiPAP/CPAP mask/device. O0110G3, CPAP: check if the non-invasive mechanical ventilator support was CPAP. -Section O Special Treatments, Procedures, and Programs - Question O0110K1, Hospice Care: Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the management of terminal illness and related conditions. Review of the clinical record indicated Resident R51 was admitted to the facility on [DATE]. Review of Resident R51's MDS dated [DATE], indicated diagnoses of high blood pressure, Chronic Obstructive Pulmonary Disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), and Post Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a physician order dated 7/12/24, indicated to administer oxygen up to 6 liters via nasal cannula as needed to maintain oxygen saturation levels between 88% to 92%. Review of a physician order dated 2/27/25, indicated Auto CPAP 15/6 pressure. Assist resident with donning (applying) every night. Fill humidifier chamber with distilled water. Check mask seal for air leaks, adjust headgear straps as needed. Apply chin strap. Resident to be assisted to lateral sleeping position with wedge pillow. Review of Resident R51's March 2025 Vitals - O2 (Oxygen) Saturation documentation revealed the resident received intermittent oxygen therapy for ten days of the 14-day look-back period. Review of Resident R51's March 2025 Treatment Administration Record revealed documentation to indicate the resident used his CPAP machine twice within the 14-day look-back period. Review of Resident R51's quarterly MDS dated [DATE], Section O - Special Treatments, Procedures, and Programs: Question O0110C1 was not checked to indicate the resident received oxygen therapy during the 14-day look-back period. Question O0110G1 was not checked to indicate the resident received non-invasive mechanical ventilator therapy during the 14 day look-back period. During an interview on 4/23/25, at 12:15 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E6 confirmed Resident R51's quarterly MDS dated [DATE], was coded incorrectly and should have been coded to capture the resident's oxygen and non-invasive mechanical ventilator therapy. Review of clinical record indicated that Resident R113 was admitted to the facility on [DATE]. Review of Resident R113's MDS dated [DATE], indicated diagnosis of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and bipolar disorder (a mental condition marked by alternating periods of elation and depression). Section O - Special Treatments, Procedures, and Programs: Question O0110K1 was checked to indicate that resident received hospice care while a resident. Review of Resident R113's clinical record failed to reveal that resident was ordered hospice services. During an interview on 4/23/25, at 11:47 a.m. RNAC Employee E6 confirmed that resident R113 has never received hospice services and that the MDS dated [DATE], was marked incorrectly. 28 Pa. Code 201.14(a)(c) Responsibility of licensee. 28 Pa. Code 211.5(f) Clinical records. 28 Pa. Code 211.12(c)(d)(5) Nursing services.

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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** 46167 Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to develop and implement a comprehensive care plan to meet care needs for two of eight residents (Residents R40 and R89). Findings include: Review of facility policy Comprehensive Care Plans last reviewed on 1/16/25, indicated that 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 that are identified in the resident's comprehensive assessment. Review of the clinical record indicated Resident R40 was admitted to the facility on [DATE]. Review of Resident R40's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/3/25, indicated diagnoses of anemia (low levels of iron in the blood), high blood pressure, and Parkinson's Disease (neuromuscular disorder causing tremors and difficulty walking). Review of a physician order dated 9/23/24, indicated to administer mirtazapine (an antidepressant) 7.5 mg (milligrams) by mouth at bedtime. Review of a physician order dated 9/23/24, indicated to administer ramelteon (a sedative/hypnotic) 8 mg by mouth at bedtime. Review of a physician order dated 2/5/25, indicated to administer Trintellix (an antidepressant) 20 mg by mouth every morning. Review of Resident R40's current care plan failed to include the development of goals and interventions related to the resident's antidepressant and sedative/hypnotic medication therapy. During an interview on 4/24/25, at 10:51 a.m. the Director of Nursing confirmed Resident R40's care plan did not reflect the use of antidepressant and sedative/hypnotic medications, and that the facility failed to develop and implement a comprehensive care plan to meet care needs for Resident R40 as required. Review of Resident R89's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R89's MDS dated [DATE], indicated diagnoses of difficulty swallowing, vitamin deficiency, and Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R89's physician order dated 4/30/20, indicated to apply bilateral lower knee TED hose (compression stockings designed to prevent blood clots, and swelling in the legs) daily at 2:30 p.m. for PVD (peripheral vascular disease, a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Review of Resident R89's current care plan failed to include use of TED hose. During an interview on 4/23/25, at 11:42 a.m. Registered Nurse Assessment Coordinator Employee E6 confirmed Resident R89's care plan did not reflect the use of TED hose, and that the facility failed to develop and implement a comprehensive care plan to meet care needs for Resident R89 as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on facility policy, clinical record review and interviews with staff, it was determined that the facility failed to revise the comprehensive care plan to reflect resident's current needs for three of six residents (Residents R29, R85, and R88). Findings include: Review of facility policy Comprehensive Care Plans (Nursing Care) dated 1/16/25, indicated the care plan will describe, at a minimum, the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Review of the admission record indicated Resident R29 admitted to the facility on [DATE]. Review of Resident R29's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/20/25, indicated diagnoses of end stage renal disease (kidneys cease to function on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), hypertension (the force of the blood against the artery walls is too high), and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Review of Resident R29's physician order dated 6/26/24, indicated sulfamethoxazole-trimethoprim (antibiotic) tablet; 400-80 milligrams twice daily for bacteremia (infection of the blood). Review of Resident R29's current care plan on 4/24/25, failed to include interventions, goals or management of the long-term antibiotic or bacteremia. Review of the admission record indicated Resident R85 admitted to the facility on [DATE]. Review of Resident R85's MDS dated [DATE], indicated diagnoses of dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), atrial fibrillation (irregular heart rhythm), and pain. Review of Resident R85's physician order dated 7/25/24, indicated check resident wander guard (a bracelet that alerts staff if a resident attempts to go beyond a supervised area) every shift for placement and functionality every night shift. Review of Resident R85's current care plan on 4/24/25, indicated the wander guard ordered 7/25/24, was not care planned timely. The care plan intervention was not initiated until 11/7/24. Interview on 4/23/25, at 12:01 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E6 confirmed Resident R29 and Resident R85's care plans were not revised to reflect the resident's current status as required. Review of the clinical record indicated Resident R88 was admitted to the facility on [DATE]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R88's MDS dated [DATE], indicated diagnoses of hemiplegia (paralysis on one side of the body), anxiety, and constipation. Review of a physician order dated 4/11/25, indicated to administer Glucerna 1.5 (a type of tube feeding formula) at 40 mL (milliliters)/hour via gastric tube (a tube surgically inserted via the abdomen into the stomach to provide nutrition). Review of Resident R88's care plan dated 6/4/24, revealed an intervention to administer Glucerna 1.5 at 35mL/hour via gastric tube continuously. During an interview on 4/23/25, at 2:59 p.m. Registered Dietitian Employee E7 confirmed that the facility failed to revise Resident R88's care plan to reflect the resident's current status as required. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on the review of facility job descriptions, clinical records, and staff interviews, it was determined that the facility failed to follow standards of professional practice for two of five residents (Residents R21 and R104). Findings include: Review of the facility job description Registered Nurse (RN) indicated the RN is to record daily care performed for the residents on the appropriate forms and the approved electronic medical record and establish and maintain effective communication with resident, family, and staff. Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE]. Review of Resident R21's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/6/25, indicated diagnoses of constipation, hypocalcemia (low levels of calcium in the blood), and Vitamin D deficiency. Review of a progress note dated 4/6/25, completed by RN Employee E16 stated, Resident continues to have menial tasks for staff that she requests one at a time. She first had RN go to her room on her way back in her wheelchair. Then, 2 minutes after RN left her room, she rang the call light. Resident seems to be anxious and incessantly wants staff in her room. In addition to the call bell, resident calls the nurses station from her phone. She flags down staff as they are walking down the hall near her. Her request are for the staff to take whatever food as a snack, she wants to talk/tell stories, she wants pulled up (even though she is a good foot and a half from the bottom of the bed and would hit her head if she were laying down and not sitting up), then she complains about her brief after she is pulled up (staff will continuously fix her location in the bed and then her brief (when one is fixed, the other bothers her and it is a continuous cycle). Resident just continuously has small requests, one at a time, continuously calling staff, or hunting them down. Resident continuously asked to make all needs known at one time. Review of a progress note dated 4/19/25, completed by RN Employee E17 stated, Resident continues to seek staff assistance/attention each time she sees someone. If resident sees someone near the door, walk by, or hears a voice, she will yell for them repeatedly. When staff acknowledge that they will be over when they are finished assisting the resident they are currently with, she acts like she does not hear it and continues to yell. However, she can hear fine other times. Then if another staff member is seen or heard, she continues to yell for them. All needs are met each time. She is fed, has a variety of drinks, is comfortable, clean and dry. She asks for multiple tasks to be completed at the same time. She will wait right beside the medication cart, resident, phone, or nurse's station while nursing is assisting another resident or on the phone and obsessively find a reason for attention. Most of the time, it is a request that could have waited until it was her turn again. She continues to monopolize each staff members time to the extent of her ability to do so. Review of the clinical record indicated Resident R104 was admitted to the facility on [DATE]. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R104's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and End-Stage Renal Disease (ESRD, an inability of the kidneys to filter the blood). Review of a progress note dated 4/21/25, completed by RN Employee E17 stated, Resident has excessively rang the call bell this morning. Each time staff enter, he whines with something he wants done. Multiple staff have assisted resident and asked if there is anything else they can do prior to leaving the room. Resident states no and then would ring the call bell very soon again. Resident is Clean and dry, he has been fed and provided with beverages, he has been repositioned, he had PRN (as needed) analgesics this AM. During an interview on 4/25/25, at 9:35 a.m. the Director of Nursing confirmed that the facility failed to follow standards of professional practice for Residents R21 and R104. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 201.29(a) Resident rights. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on review of facility policy, clinical records, observations, and interviews with staff, it was determined that the facility failed to make certain that residents received proper treatment for pressure ulcers for two of four residents (Residents R21 and R88) and failed to make certain that residents received the necessary services to prevent pressure ulcers/wounds from developing for one of four residents (Resident R133). Findings include: Review of the facility policy Management of Pressure Injuries dated 1/16/25, indicated the facility will use a standardized plan for defining, assessing, documenting, and implementing strategies for the prevention and treatment of pressure injuries on all residents. Braden Scale will be the instrument used to determine the potential or actual risk for pressure ulcers. Residents who score between 15-18 are at risk. Utilization of pressure relieving devices, including special mattresses, elbow, and heel protectors may be used. Residents with pressure ulcers shall receive dressing changes based upon stage and severity of the wounds. Review of facility policy Management of Pressure Injuries dated 1/16/25, indicated residents with pressure ulcers shall receive dressing changes based upon stage and severity of the wounds. Review of the facility Licensed Practical Nurse (LPN) job description indicated the LPN will administer medications and treatments timely and accurately as ordered by a physician. Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE]. Review of Resident R21's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/6/25, indicated diagnoses of constipation, hypocalcemia (low levels of calcium in the blood), and Vitamin D deficiency. Review of a physician order dated 1/2/25, indicated to cleanse sacral (base of spinal column) wound with 1/4 strength Dakin's solution (an antiseptic cleanser) - lightly packing undermining and tunneling with Calcium Alginate AG (a highly absorbent dressing). Cover wound bed with collagen (used to promote new tissue growth). Cover with foam dressing every other day and PRN (as needed). Review of Resident R21's March 2025 Medication Administration Record (MAR) indicated the treatment was not documented as completed on the following shift: - 3/30/25 6:30 a.m. to 2:30 a.m., the documented reason was, done by night staff Review of Resident R21's clinical record failed to include additional documentation that the treatment was performed on 3/30/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a physician order dated 3/31/25, indicated to wash coccyx (tailbone) with soap/water. Apply prisma (a type of dressing that promotes wound healing while preventing infection) to wound base with exufiber (a highly absorbent dressing) to surrounding tunneling and remaining wound, cover with foam dressing QOD (every other day) and PRN. Review of Resident R21's April 2025 MAR indicated the treatment was not documented as completed on the following shift: - 4/20/25 2:30 p.m. to 10:30 p.m., the documented reason was, done 4/19 Review of Resident R21's clinical record failed to include additional documentation that the treatment was performed on 4/19/25. Review of the clinical record indicated Resident R88 was admitted to the facility on [DATE]. Review of Resident R88's MDS dated [DATE], indicated diagnoses of hemiplegia (paralysis on one side of the body), anxiety, and constipation. Review of a physician order dated 11/7/23, indicated to apply Dakin's 0.25% soaked gauze packed to sacral wound daily. Cover with foam dressing. Review of Resident R88's April 2025 MAR indicated the treatment was not documented as completed on the following shifts: - 4/18/25, 6:30 a.m. to 2:30 p.m., the documented reason was, prior shift - 4/19/25, 6:30 a.m. to 2:30 p.m., the documented reason was, previous shift did Review of Resident R88's clinical record failed to include additional documentation that the treatment was performed on 4/18/25, and 4/19/25. During an interview on 4/24/25, at 2:45 p.m. the Director of Nursing confirmed that the facility failed to make certain that Residents R21 and R88 received proper treatment for pressure ulcers as required. Review of Resident R133's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R133's MDS dated [DATE], indicated diagnoses of high blood pressure, depression, and cancer (an uncontrolled growth and division of abnormal cells). MDS Section GG Functional Abilities, Line H labeled- putting on/taking off footwear is coded as a 1, dependent, helper does all of the effort. Review of Resident R133's Braden scale dated 1/8/25, revealed resident scored an 18, high risk for pressure injury. Review of Resident R133's physician order dated 1/8/25, indicated bilateral Prevalon boots (padded boot that Velcro's around the foot to stay in place) while in bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R133's care plan dated 1/9/25, indicated resident is to wear bilateral Prevalon boots while in bed due to impaired mobility to prevent pressure injury/impaired skin integrity. During an observation on 4/21/25, at 10:50 a.m. resident was lying in bed and failed to have Prevalon boots on. During an interview on 4/21/25, at 10:55 a.m. Registered Nurse (RN) Employee E8 confirmed that Resident R133's Prevalon boots were sitting at bedside and resident failed to have them on per physician orders. RN Employee E8 confirmed that the failed to make certain that Resident R133 received the necessary services to prevent pressure ulcers/wounds from developing. During an observation on 4/25/25, at 9:25 a.m. resident was lying in bed and failed to have Prevalon boots on. During an interview on 4/25/25, at 9:31 a.m. LPN Employee E11 confirmed that Resident R133's Prevalon boots were sitting near the window and resident failed to have them on per physician orders. LPN Employee E11 confirmed that facility failed to make certain that Resident R133 received the necessary services to prevent pressure ulcers/wounds from developing. 28 Pa. Code 201.18 (b)(1) Management. 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 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** 48546 Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for three of five residents (Residents R13, R31, and R51). Findings include: Review of facility policy Supplemental Oxygen Therapy dated 1/16/25, indicated used cannulas, masks, and tubing shall be stored in a plastic bag, off the floor, labeled with the Resident's name, when not in use. Review of facility policy Noninvasive Ventilation: BiPAP, CPAP dated 1/16/25, indicated when not in use, assembled headgear, masks, and tubing shall be stored in a plastic bag, labeled with the resident's name and date. Review of Resident R13's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R13's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/3/25, indicated the diagnoses of coronary artery disease (narrow arteries decreasing blood flow to heart), hypertension (the force of the blood against the artery walls is too high), and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Review of Resident R13's physician order dated 3/4/25, indicated BiPAP equipment care to be completed every week on Sundays, on daylight shift, that includes replacing the storage bag for mask, tubing, and headgear and label with resident' s name and current date. During an observation on 4/21/25, at 9:27 a.m. Resident R13's BiPAP machine was observed on the nightstand beside the bed with the BiPAP mask sitting beside it, not in the storage bag as required. During an interview on 4/21/25, at 10:00 a.m. Registered Nurse (RN) Employee E15 confirmed Resident 13's BiPAP was not properly stored in a plastic bag while not in use and the facility failed to provide appropriate respiratory care for Resident R13. Review of Resident R31's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R31's MDS dated [DATE], indicated diagnoses of peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), depression, and sleep apnea (a condition when you stop breathing while your sleeping). Review of a physician order dated 3/4/25, indicated a BiPAP with six liters of oxygen to be administered every night at bedtime. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a physician order dated 3/4/25, indicated BiPAP equipment care to be completed every week on Sundays, on daylight shift, that includes replacing the storage bag for mask, tubing, and headgear and label with resident ' s name and current date. During an observation on 4/21/25, at 10:25 a.m. Resident R31's BiPAP machine was observed on the nightstand beside the bed with the BiPAP mask sitting beside it. No storage bag was observed. During an interview on 4/21/25, at 10:29 a.m. Licensed Practical Nurse Employee E9 confirmed Resident R31's BiPAP was not properly stored in a plastic bag while not in use and the facility failed to provide appropriate respiratory care for Resident R31. Review of the clinical record indicated Resident R51 was admitted to the facility on [DATE]. Review of Resident R51's MDS dated [DATE], indicated diagnoses of high blood pressure, Chronic Obstructive Pulmonary Disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), and Post Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions). Review of a physician order dated 7/12/24, indicated to administer oxygen up to 6 liters via nasal cannula as needed to maintain oxygen saturation levels between 88% to 92%. Review of a physician order dated 7/12/24, indicated to clean oxygen concentrator filter and change and label the following with date weekly on Sunday evening shift. 1. Nasal cannula tubing/mask/neb tubing. 2. Distilled water container. 3. Plastic storage bag(s), label with resident name in addition. Review of a physician order dated 2/27/25, indicated to assist resident with doffing (removing) CPAP upon awakening. Empty humidifier chamber of any remaining water. Place mask/tubing/headgear into plastic labeled storage bag. During an observation on 4/21/25, at 10:10 a.m. Resident R51's nasal cannula was observed lying on the floor to the left of the resident's bed. During this observation, Resident R51's CPAP machine was observed on a bedside table to the right of the bed. The CPAP mask was observed sitting on top of the machine. During an observation on 4/21/25, at 10:38 a.m. Resident R51's nasal cannula tubing was observed wrapped around the oxygen flow meter, now off of the floor. During this observation, Infection Preventionist Employee E1 was informed that the nasal cannula was previously observed on the floor. During an interview on 4/21/25, at 10:38 a.m. Infection Preventionist Employee E1 confirmed Resident R51's nasal cannula and CPAP were not properly stored in a plastic bag while not in use and that the facility failed to provide appropriate respiratory care for Resident R51. Review of Resident R51's care plan on 4/22/25, failed to include the development of a plan of care and interventions for the resident's oxygen therapy and CPAP therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/25, at 12:09 p.m. Registered Nurse Assessment Coordinator Employee E6 confirmed that the facility failed to develop a plan of care and interventions related to Resident R51's oxygen and CPAP therapy. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policy and clinical record and staff interview it was determined that the facility failed to make certain consistent dialysis communication was maintained for two of three residents. (Residents R33 and R104). Findings include: Review of the facility policy Pre and Post Dialysis dated 1/16/25, indicated prior to departing the unit for transfer to dialysis (the clinical purification of blood by dialysis as a substitute for the normal function of the kidney), the licensed staff will complete the Dialysis Communication Form with each transfer to the dialysis clinic. Upon return to the unit, the licensed staff will complete the return portion of the Dialysis Communication Form and file in the appropriate section of the chart. If no communication form is received, please call dialysis, and have one faxed to the facility. Review of the admission record indicated Resident R33 was admitted to the facility on [DATE]. Review of Resident R33's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/13/25, indicated the diagnoses of renal failure (condition where the kidneys lose the ability to remove waste and balance fluids) with dialysis, stroke (damage to the brain from an interruption of blood supply), and hemiplegia (paralysis of one side of the body). Review of the physician order dated 3/24/25, indicated that Resident R33 goes to dialysis on Monday, Wednesday and Friday. Review of Resident R33's current care plan indicated dialysis communication sheet to be sent with resident for completion by dialysis clinic to return to facility on days treatment to include: any problems, new orders, dialysis treatment, dialysis duration, pre-weight and blood pressure, and temperature. Post treatment weight, blood pressure, temperature, any adverse effects (fever, prolonged bleeding), bleeding, and any labs performed with signature and contact information. Review of the clinical record did not include complete communication forms for thirteen days during the period of 2/3/25, through 4/16/25. The incomplete forms were on the following dates: 2/3/25, 2/5/25, 2/7/25, 2/10/25, 2/17/25, 2/19/25, 2/28/25, 3/12/25, 3/19/25, 3/31/25, 4/11/25, 4/14/25, and 4/16/25. Interview on 4/21/25, at 12:19 p.m. Registered Nurse (RN) Employee E15 confirmed the above dates did not include complete communication forms as required for Resident R33. Review of the clinical record indicated Resident R104 was admitted to the facility on [DATE]. Review of Resident R104's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and End-Stage Renal Disease (ESRD, an inability of the kidneys to filter the blood). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a physician order dated 3/24/25, indicated the resident receives dialysis treatment at an outside facility every Monday, Wednesday, and Friday. Review of Resident R104's care plan dated 11/28/23, indicated to prepare Dialysis Communication Form for daylight shift by completing the ENTIRE first page of the form. Special instructions: pass form to daylight nurse at change of shift. Review of Resident R104's clinical record did not include complete communication forms for three days during the period of 3/1/25, through 4/22/25. The incomplete forms were on the following dates: 4/4/25, 4/7/25, and 4/16/25. During an interview on 4/22/25, at 10:47 a.m. Licensed Practical Nurse Employee E3 confirmed the above dates did not include complete dialysis communication forms and that the facility failed to make certain consistent dialysis communication was maintained for Resident R104. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.5(f) Medical records. 28 Pa. Code: 211.12(c)(d)(1)(3)(5) Nursing services.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, resident record review, and staff interviews, it was determined that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for two of four residents (Residents R7 and R51). Findings include: Review of facility policy Culturally Competent, Trauma Informed Care dated 1/16/25, indicated the purpose of this protocol is to provide guidance to the facility to guide staff in providing appropriate, culturally competent care to residents who have experienced a trauma and to safeguard re-traumatization by employing supportive services related to minimizing triggers. The facility will assess each resident for a history of trauma and cultural preferences, upon admission, annually and with significant change. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, discussing cultural needs and social history. The resident's Plan of Care will be implemented with individualized interventions that include trigger specific interventions addressing ways to decrease re-traumatization, as well as identifying ways to mitigate or decrease the effect of the trigger on the resident. In situations where a trauma survivor is reluctant to share their history, the facility will try to identify triggers which may re-traumatize the resident, and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident. Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE]. Review of Resident R7's Minimum Data Set (MDS - a periodic review of a care needs) dated 3/6/25, indicated diagnoses of hemiplegia (paralysis on one side of the body), Post Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions), and pain in left hip. Review of Resident R7's care plan dated 12/6/24, indicated the resident has an increased risk of behavior and emotional distress related to post traumatic stress disorder stemming from an automobile accident and assault/shooting by a neighbor. Review of Resident R7's PTSD assessment dated [DATE], indicated the resident's reported triggers were loud noises. Review of a progress note dated 12/6/24, completed by Social Work (SW) Employee E14 stated, SW completed PCL-5 Assessment for PTSD with resident in his room. He has a current score of 58, and reports that the PTSD stemmed from an automobile accident and an assault by a neighbor in which he was attacked and shot. His score does support his PTSD diagnosis and indicates ongoing symptoms of that condition. SW will review his PTSD care plan to be sure it is accurate and takes appropriate steps to avoid resident's triggers. A copy of the PCL-5 completed today will be stored in resident's clinical documents. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/25, at 11:32 a.m. Social Work Director Employee E4 stated PTSD assessments are completed within 30 days of admission. During an interview on 4/24/25, at 11:32 a.m. Social Work Director Employee E4 confirmed Resident R7 should have had a PTSD assessment performed and care plan developed within 30 days of the resident's admission to the facility on [DATE], and that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for Resident R7. Review of the clinical record indicated Resident R51 was admitted to the facility on [DATE]. Review of Resident R51's MDS dated [DATE], indicated diagnoses of high blood pressure, Chronic Obstructive Pulmonary Disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), and Post Traumatic Stress Disorder. Review of Resident R51's care plan dated 4/25/24, indicated the resident has an increased risk for of behavioral and emotional distress related to post traumatic stress disorder due to experiences in combat during Vietnam War. The resident's care plan failed to include identified triggers or documentation indicating the resident declined to identify triggers related to the resident's PTSD. During an interview on 4/24/25, at 11:25 a.m. Social Work Director Employee E4 confirmed that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for Resident R51. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of personnel records and staff interview it was determined that the facility failed to complete annual performance evaluation for one of three nurse aide (NA) personnel records (NA Employee E18). Findings include: Review of CFR (Code of Federal Regulations) S483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of S483.95(g). Review of NA Employee E18's personnel record indicated she was hired to the facility on [DATE]. Review of personnel records did not include an annual performance evaluation based on the date of hire for NA Employee E18. Interview on 4/22/25, at 1:16 p.m. Human Resource's Employee E5 confirmed that the facility failed to complete annual performance evaluation based on date of hire for NA Employee E18. 28 Pa Code: 201.14 (b) Responsibility of licensee 28 Pa Code: 201.18 (b)(1)(3) Management

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on clinical record review and staff interview, it was determined that the facility failed to maintain complete and accurate documentation for five of eight residents (Residents R13, R16, R21, R91, and R104). Findings include: Review of the facility policy Permitted Charges for Medical Records dated 1/16/25, indicated the medical record is an accounting of events and interactions between an individual and a healthcare provider. Medical records assist in analyzing trends in healthcare use, an individual's characteristics and quality of care. Review of the facility job description Registered Nurse (RN) indicated the RN is to record daily care performed for the residents on the appropriate forms and the approved electronic medical record and establish and maintain effective communication with resident, family, and staff. Review of Resident R13's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R13's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/3/25, indicated the diagnoses of coronary artery disease (narrow arteries decreasing blood flow to heart), hypertension (the force of the blood against the artery walls is too high), and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Review of Resident R13's current physician orders on 4/23/25, indicated check and record vitals (temperature, pulse, blood pressure, oxygen saturation, respirations, and weight) on the fifth of each month per facility policy. Special instructions - weights can be started at the beginning of each month; weight and vitals are due to be completed and recorded by the fifth of each month. Review of Resident R13's weight record in the Electronic Medical Record (EMR) on 4/23/25, at 1:15 p.m., failed to include a documented weight for the month of April 2025. Interview on 4/24/25, at 3:05 p.m. Registered Dietitian Employee E7 confirmed that the weights should be entered into the EMR, and the facility failed to maintain complete and accurate documentation for Resident R13. Review of the clinical record indicated Resident R16 was admitted to the facility on [DATE]. Review of Resident R16's MDS dated [DATE], indicated diagnoses of high blood pressure, anemia (too little iron in the blood), and hyperlipidemia (high levels of fat in the blood). (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a physician order dated 2/13/23, indicated to check and record vitals (temperature, pulse, blood pressure, oxygen saturation, respirations, and weight) on the 5th of each month, per facility policy. Weights can be started at the beginning of each month; weights and vitals are due to be completed and recorded by the 5th of each month. Review of Resident R16's weight record in the EMR on 4/23/25, failed to include a documented weight for the month of December 2024. Review of Resident R16's December 2024 Medication Administration Record (MAR) indicated the resident's weight was not performed on 12/5/24, as ordered. The documented reason was, already complete. During an interview on 4/23/25, at 2:57 p.m. Registered Dietitian Employee E7 confirmed Resident R16's weight was not documented in the EMR and that the facility failed to maintain complete and accurate documentation for Resident R16. Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE]. Review of Resident R21's MDS dated [DATE], indicated diagnoses of constipation, hypocalcemia (low levels of calcium in the blood), and Vitamin D deficiency. Review of a progress note dated 4/6/25, completed by RN Employee E16 stated, Resident continues to have menial tasks for staff that she requests one at a time. She first had RN go to her room on her way back in her wheelchair. Then, 2 minutes after RN left her room, she rang the call light. Resident seems to be anxious and incessantly wants staff in her room. In addition to the call bell, resident calls the nurses station from her phone. She flags down staff as they are walking down the hall near her. Her request are for the staff to take whatever food as a snack, she wants to talk/tell stories, she wants pulled up (even though she is a good foot and a half from the bottom of the bed and would hit her head if she were laying down and not sitting up), then she complains about her brief after she is pulled up (staff will continuously fix her location in the bed and then her brief (when one is fixed, the other bothers her and it is a continuous cycle). Resident just continuously has small requests, one at a time, continuously calling staff, or hunting them down. Resident continuously asked to make all needs known at one time. Review of a progress note dated 4/19/25, completed by RN Employee E17 stated, Resident continues to seek staff assistance/attention each time she sees someone. If resident sees someone near the door, walk by, or hears a voice, she will yell for them repeatedly. When staff acknowledge that they will be over when they are finished assisting the resident they are currently with, she acts like she does not hear it and continues to yell. However, she can hear fine other times. Then if another staff member is seen or heard, she continues to yell for them. All needs are met each time. She is fed, has a variety of drinks, is comfortable, clean and dry. She asks for multiple tasks to be completed at the same time. She will wait right beside the medication cart, resident, phone, or nurse's station while nursing is assisting another resident or on the phone and obsessively find a reason for attention. Most of the time, it is a request that could have waited until it was her turn again. She continues to monopolize each staff members time to the extent of her ability to do so. During an interview on 4/25/25, at 9:35 a.m. the Director of Nursing (DON) confirmed that the facility failed to chart accurately and appropriately for Resident R21 as required. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39A438	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwestern Veterans Center	7060 Highland Drive Pittsburgh, PA 15206

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R91's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R91's MDS dated [DATE], indicated the diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), Parkinson's Disease (disorder of the nervous system that results in tremors), and depression. Review of Resident R91's current physician orders on 4/23/25, indicated check and record vitals (temperature, pulse, blood pressure, oxygen saturation, respirations, and weight) on the fifth of each month per facility policy. Special instructions - weights can be started at the beginning of each month; weight and vitals are due to be completed and recorded by the fifth of each month. Review of Resident R91's weight record in the Electronic Medical Record (EMR) on 4/23/25, at 2:00 p.m., failed to include a documented weight for the month of April 2025. Interview on 4/24/25, at 3:05 p.m. Registered Dietitian Employee E7 confirmed that the weights should be entered into the EMR, and the facility failed to maintain complete and accurate documentation for Resident R91. Review of the clinical record indicated Resident R104 was admitted to the facility on [DATE]. Review of Resident R104's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia, and End-Stage Renal Disease (ESRD, an inability of the kidneys to filter the blood). Review of a physician order dated 11/28/23, indicated to obtain monthly weight. Special instructions: monthly weights are to be completed by the 5th day of every month and reweighed if +5 or -5 pound difference. Review of Resident R104's weight record in the EMR on 4/23/25, failed to include a documented weight for the month of November 2024. Review of Resident R104's November 2024 MAR indicated the resident's weight was not performed on 11/5/24, as ordered. The documented reason was, already done. During an interview on 4/23/25, at 2:57 p.m. Registered Dietitian Employee E7 confirmed Resident R104's weight was not documented in the EMR and that the facility failed to maintain complete and accurate documentation for Resident R104. Review of a progress note dated 4/21/25, completed by RN Employee E17 stated, Resident has excessively rang the call bell this morning. Each time staff enter, he whines with something he wants done. Multiple staff have assisted resident and asked if there is anything else they can do prior to leaving the room. Resident states no and then would ring the call bell very soon again. Resident is Clean and dry, he has been fed and provided with beverages, he has been repositioned, he had PRN (as needed) analgesics this AM. During an interview on 4/25/25, at 9:35 a.m. the DON confirmed that the facility failed to chart accurately and appropriately for Resident R104 as required. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39A438	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwestern Veterans Center	7060 Highland Drive Pittsburgh, PA 15206

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.5(f) Medical records. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39A438	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to maintain proper infection control practices related to the care of indwelling urinary catheters (tube inserted in the bladder to drain urine) for one of three residents reviewed (Residents R107). Findings include: Review of facility policy Urinary Catheter Procedures dated 1/16/25, indicated the purpose is to promote a healthy urinary tract, promote continence, and to maintain healthy skin integrity. To achieve free flow of urine the collection bags, tubing is never to touch the floor. Review or facility policy Infection Control Plan dated 1/16/25, indicated policy is to maintain a consistent, comprehensive approach to the prevention and management of infections. The goal of the program is to provide a safe and sanitary environment, decrease the risk of infection to residents, and correct problems relating to infection control practices. Review of Resident R107's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R107's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 3/6/25, indicated diagnoses of high blood pressure, cancer (an uncontrolled growth and division of abnormal cells), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of a physician order dated 6/14/24, indicated the resident has a foley catheter for obstructive uropathy (a blockage in the flow of urine). During an observation on 4/21/25, at 10:50 a.m. Resident R107 was sitting in a wheelchair beside his bed watching tv and his catheter bag was lying directly on the floor beside him. During an interview on 4/21/25, at 10:53 a.m. a.m. Registered Nurse (RN) Employee E8 confirmed Resident R107's catheter collection bag was on the floor and that the facility failed to maintain proper infection control practices related to Resident R107's indwelling urinary catheter as required. 28 Pa. code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b) (1) (e) (1) Management. 28 Pa. Code: 211.10 (d) Resident care policies. 28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services