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	05/15/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations and staff interview, it was determined that the facility failed to maintain a resident's confidential personal and medical records for one of eight residents (Resident R4). Findings include: A review of the facility policy titled, Health Insurance Portability and Accountability Act dated 1/16/26, indicated that all staff must maintain the confidentiality and security of private health information in daily practice. 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, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and dysphagia (difficulty swallowing). During an observation on 5/11/26, at 1:56 p.m. Resident R4 was observed in his room resting in a wheelchair, with a sign posted above is bed that stated I only eat pureed food. Review of Resident R4's clinical record failed to include any documentation that the above resident or their representatives approved the posting of private health information. During an interview on 5/14/26, at 10:05 a.m. Registered Nurse Employee E3 confirmed that the facility failed to maintain resident's confidential personal, and medical records for one of eight residents (Resident R4). 28 Pa. Code: 201.18(e)(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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 two of eight residents sampled with facility-initiated transfers (Residents R11 and R164).Findings include: Review of the facility policy Transfers and discharge date d 1/16/26, indicated that for a transfer to another provider the following information must be provided to the receiving provider: Contact information of the practitioner who was responsible for the care of the resident Resident representative information, including contact information Advance directive information All other information necessary to meet the resident's needs, which includes, but may not be limited to: Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs Diagnoses and allergies Medications (including when last received) Most recent relevant labs, other diagnostic tests, and recent immunizations All special instructions and/or precautions for ongoing care, as appropriate such as: Treatments and devices Transmission- based precautions such as contact, droplet, or airborne Special risk such as for falls, elopement, bleeding, or pressure injury and/or aspiration precautions The resident's comprehensive care plan goals Additional information, if there is any, outlined in the transfer agreement with the acute care provider. Review of the clinical record indicated Resident R11 was admitted to the facility on [DATE]. Review of Resident R11's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/2/26, indicated diagnoses of high blood pressure, obstructive uropathy (a blockage in the urinary tract that prevents normal urine flow), and constipation (fewer than three bowel movements per week). (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record indicated Resident R11 was transferred to the hospital on 3/29/26, and returned to the facility on 4/1/26. Review of Resident R11's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the resident's transfer and expected return: the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R164 was admitted to the facility on [DATE]. Review of Resident R164's MDS dated [DATE], indicated diagnoses of high blood pressure, dysphagia (difficulty swallowing, and hemiplegia (paralysis on one side of the body). Review of the clinical record indicated Resident R164 was transferred to the hospital on 3/28/26, and returned to the facility on 3/31/26. Review of Resident R164'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. During an interview on 5/13/26, at 1:53 p.m. the Quality Assurance Coordinator Employee E1 confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of eight residents sampled with facility-initiated transfers (Residents R11, and R164). 28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights.

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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 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, clinical record review, and staff interviews, it was determined that the facility failed to make certain that residents were provided appropriate treatment and care for two of six residents (Resident R3, and R30).Findings include: Review of the facility policy Vital Signs, Height and Weight dated 1/16/26, indicated that weights are obtained on admission, and monthly. Weights may be taken on a more frequent schedule such as weekly or daily per physician order. Weights are recorded in the electronic health record. Review of the facility policy Transcription of Physician Orders, dated 1/16/26, indicated that physician orders will be added into the electronic medical record. All new physician orders for medications and treatments are to be reviewed and added to electronic medical administration record as written by the physician. To clarify an order the licensed staff must never add to or change the order in question. Review of the clinical record indicated Resident R30 was admitted to the facility on [DATE]. Review of Resident R30's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/2/26, indicated diagnoses of pneumonia, hypoxemia (low levels of oxygen in the blood) and urine retention. Review of Resident R30's physician order history dated 9/23/25-2/25/26, indicated to tamsulosin capsule; 0.4 mg; amt: 2; oral, Once A Day, 08:00 PM. 2/25/26- 3/18/26 tamsulosin capsule; - Crushed; 0.4 mg; amt: 0.8mg; oral Special Instructions: open capsule and sprinkleTwice A Day 08:00 AM, 08:00 PM 3/18/26-4/22/26 tamsulosin capsule; - Crushed; 0.4 mg; amt: 0.8mg; oral Special Instructions: opencapsule and sprinkle Once A Day 08:00 AM During an interview completed on 5/13/26, at 11:00 a.m. QA Coordinator Employee E1 confirmed that the facility transcribed the physician order incorrectly and did not follow the physician order. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and low back pain. Review of Resident R3's physician orders dated 3/7/25, indicated to check weight at 11 a.m. daily, and notify physician if there is weight gain of five pounds or more in three days. Review of Resident R3's clinical record indicated that weights were not obtained on the following days: 4/20/26, 4/21/26, 4/22/26, 4/23/26, 4/24/26, and 4/28/26. During an interview completed on 5/14/26, at 10:10 a.m. Registered Nurse Employee E5 confirmed that the facility failed to weight Resident R3 daily as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code: 201.14(a) Responsibility of licensee.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)(2)(3)(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 a review of facility policy, clinical record review and staff interview, it was determined that the facility failed to implement resident's specific nutritional interventions in a timely manner, and failed to develop an individualized care plan to address the resident's specific nutritional concerns for one of eight (Resident R189) records reviewed.Findings include: Review of facility policy Nutrition dated 1/16/26, indicated to indicate nutrition in the resident's total plan of care, to identify residents at risk of poor nutrition status, to facilitate communication with the health care team. Nutritional assessment and resident care plan documentation will be provided for all residents and provide initial and regular review of nutritional care. Initial nutritional assessment is completed by the Registered Dietitian within 7 days of admission to the facility. Nutrition care plans will be completed upon admission, and reviewed quarterly, and when a resident has a significant change in his/her nutritional status. Care plans will be updated on an ongoing basis when approaches change. Review of facility policy Resident Care: Nursing Services: Plan of Care and RAI, MDS dated [DATE], indicated the purpose is to provide guidance regarding the development and implementation of a baseline care plan, to promote continuity of care and communication among staff, increase resident safety, and safeguard against adverse events that are more likely to occur right after admission. Review of admission documents indicated that Resident R189 was admitted to facility 5/5/26, with diagnoses of Alzheimer's disease (progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior), dementia (group of symptoms affecting memory, thinking and social abilities), and high blood pressure. Review of physician order dated 5/5/26, indicated Resident R189 Dietary order House, Thin, Pureed Special Instructions: no straws. Review of Comprehensive Nutritional assessment dated [DATE], indicated that Resident R189's Nutrition Orders: House diet, pureed foods, thin liquids. Feeding ability: Staff feed. Further review indicated Skin condition location and description: Stage 2 (partial thickness skin loss), coccyx. Initiate plan of care. Review of Comprehensive Nutritional Assessment progress note dated 5/5/26, indicated Resident R189 ate very little for lunch today. Visited with resident, unable to obtain dietary history and food and beverage preference from her, POA (Power of Attorney) provided some food and beverage preferences. Adding fortified shakes with all meals and Gelatein Plus (oral nutritional supplement) with lunch to support wound healing. Additional review of Resident R189's physician orders on 5/13/26, failed to indicate a current order for Gelatein Plus as recommended. Review of Resident R189's current plan of care failed to identify focus, goals, and interventions related to nutrition care and services. During an interview on 5/13/26, at 10:33 a.m., Registered Dietitian (RD) Employee E6 stated that she forgot to add Gelatein Plus to Resident R189's physician orders as recommended, and forgot to develop a baseline care plan to address nutrition care and services within 48 hours of admission, confirming that the facility failed to implement resident's specific nutritional interventions in a timely manner, and failed to develop an individualized care plan to address the resident's specific nutritional concerns for Resident R189. 28 Pa. Code: 201.18(b)(1)(e)(1) Management.28 Pa. Code: 211.12(d)(3)(5)Nursing services.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that residents with an enteral feeding tube (G- Tube, a tube inserted in the stomach through the abdomen) received appropriate treatment and services to prevent potential complications for one of four residents (Residents R149).Findings include: Review of the facility policy Enteral Feedings Gastrostomy last reviewed 1/16/26, indicated to elevate head of bed a minimum of 45 degrees (or as per physician order) and instruct resident to remain in that position during and for 45 minutes after the feeding for bolus feedings. For continuous feedings, head of bed must remain at a minimum of 45 degrees (or as per physician order) at all times, unless pump is stopped to provide care. Review of the admission record indicated Resident R149 admitted to the facility on [DATE]. Review of Resident R149's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/5/26, indicated the diagnoses of Parkinson's Disease (disorder of the nervous system that results in tremors), dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), and seizure disorder (a person experiences abnormal behaviors, symptoms and sensations, sometimes including loss of consciousness). Review of Resident R149's physician order dated 4/22/26, indicated Jevity 1.5 at 120 milliliters (ml)/hour from 8:00 a.m. through 8:00 p.m. Further review of Resident R149's physician order dated 4/20/26, indicated keep head of bed at 30 degrees at all times. Review of Resident R149's care plan dated 4/21/26, indicated to keep head of bed at 30 degrees at all times. Observation on 5/11/26, at 10:51 a.m. Resident R149 was observed lying flat in bed with the tube feeding connected and the pump indicated the feeding was infusing at 120 ml/hr. Observation and interview on 5/11/26, at 10:53 a.m. Licensed Practical Nurse (LPN) Employee E2 confirmed that Resident R149 was lying flat in bed with the tube feeding connected and the pump indicated the feeding was infusing at 120 ml/hr. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.10(c) Resident care policies.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to provide evidence medication regimen reviews (MRR) were reviewed by the resident's attending physician monthly for two of seven residents (Resident R3, and R4).Finding include: Review of the facility policy Drug Regimen Review, Monthly dated 1/16/26, indicated that the pharmacist will review the drug regimen of every resident's care levels every month and report results to the physician, and the physician will respond in the comment section. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/26/26, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and low back pain. Review of Resident R3's Medication Review Regimen dated 4/3/26, failed to include a response from the resident's attending physician. A Certified Registered Nurse Practitioner (CRNP) signed the note to the attending physician on 4/23/26, and the decision was made to review lab work and implement a vitamin D supplement. 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, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and dysphagia (difficulty swallowing). Review of Resident R4's Medication Review Regimen dated 4/16/26, failed to include a response from the resident's attending physician.A CRNP signed the note to the attending physician on 5/12/26, and the decision was made to discontinue the following medication:-Voltaren gel (a medicated gel that relieve joint pain)) During an interview on 5/14/26, at 11:353 a.m. Quality Assurance Coordinator Employee E1 confirmed facility failed to ensure resident's medication regimen reviews (MRR) were reviewed by the resident's attending physician monthly for two of seven residents (Resident R3, and R4). 28 Pa. Code: 201.14 (a) Responsibility of licensee.28 Pa. Code 211.5(f) Medical records.28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.