STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395028	A. BLDG: __--_____ B. WING: _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SQUIRREL HILL WELLNESS AND REHABILITATION CENTER STATE LICENSE NUMBER: **231602**	**2025 WIGHTMAN STREET PITTSBURGH, PA 15217**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on February 6, 2025, it was determined that Squirrel Hill Wellness and Rehabilitation Center was not in compliance with the requirements of 42 CFR 483.73.	E 0000		
E 0004 SS=C	483.73(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and	E 0004	Emergency preparation will be updated by 3/21/2025. An annual review will be audited by the Maintenance Director or designee. Findings will be reported to the Quality Assurance and Performance Improvement committee meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/21/2025**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SQUIRREL HILL WELLNESS AND REHABILITATION CENTER STATE LICENSE NUMBER: **231602**	**2025 WIGHTMAN STREET PITTSBURGH, PA 15217**

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E 0004 SS=C	Continued from page 1 maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by:	E 0004		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SQUIRREL HILL WELLNESS AND REHABILITATION CENTER STATE LICENSE NUMBER: **231602**	**2025 WIGHTMAN STREET PITTSBURGH, PA 15217**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
E 0004 SS=C	Continued from page 2 Based on a review of the facility's Emergency Preparedness (EP) Plan, it was determined the facility failed to review and update their emergency plan at least annually. Findings include: 1. Interview and documentation review on February 6, 2025, at 8:05 a.m., revealed the Emergency Preparedness Plan was not updated in over 12 months. Interview with the Facility Administrator and Maintenance Director on February 6, 2025, at 1:00 p.m., confirmed the EP plan was not reviewed and updated at least annually.	E 0004		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395028	A. BLDG: __--_____ B. WING: _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SQUIRREL HILL WELLNESS AND REHABILITATION CENTER	**2025 WIGHTMAN STREET PITTSBURGH, PA 15217**
STATE LICENSE NUMBER: **231602**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
E 0004 SS=C	Continued from page 3	E 0004		
E 0006 SS=C	483.73(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an	E 0006	Facility based/community-based risk assessment will be completed by 3/21/2025. An annual review of the risk assessment will be conducted by the Administrator or designee. Findings will be reported to the Quality Assurance and Performance Improvement committee meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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E 0006 SS=C	Continued from page 4 all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by:	E 0006		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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E 0006 SS=C	Continued from page 5 Based on document review and interview it was determined that the facility failed to provide a written Emergency Preparedness Plan (EP) Plan that includes an updated facility-based and community-based risk assessment. Findings include: 1. Interview and documentation review on Febrauary 6, 2025, at 8:30 a.m., revealed the facility failed to update the facility-based/community-based risk assessment, utilizing an all-hazards approach. Interview with the Facility Administrator and Maintenance Director on February 6, 2025, at 1:00 p.m., confirmed the listed EP plan deficiency.	E 0006		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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E 0007 SS=C	483.73(a)(3) EP Program Patient Population §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by:	E 0007	Adopted Policy and procedure for addressing patient population, including, but not limited to, persons at risk into facility's emergency preparedness plan by 3/21/2025. A review of policies and procedures will be conducted on an annual basis by the Administrator or designee. Findings will be reported to the Quality Assurance and Performance Improvement committee meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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E 0007 SS=C	Continued from page 7	E 0007		

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E 0007 SS=C	Continued from page 8 Based on document review and interview, it was determined the facility failed to ensure policies and procedures were in place addressing patient population. Including, but not limited to: persons at-risk, the type of services the facility has the ability to provide in an emergency, and continuity of operations, including delegations of authority and succession plans, affecting the entire facility. Findings include: 1. Document review on February 6, 2025, at 8:45 a.m., revealed the facility's Emergency Preparedness Plan did not include policies and procedures addressing patient population, including, but not limited to, persons at-risk. Exit Interview with the Facility Administrator and Maintenance Director on February 6, 2025, at 1:00 p.m., confirmed the lack of documentation.	E 0007		

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E 0029 SS=F	483.73(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.542(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. This REQUIREMENT is not met as evidenced by:	E 0029	Facility emergency preparedness plan will be updated to include communication plan that complies with local, state and federal laws by 3/21/2025. A review of policies and procedures will be conducted on an annual basis by the Administrator or designee. Findings will be reported to the Quality Assurance and Performance Improvement committee meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/21/2025**

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E 0029 SS=F	Continued from page 10 Based on a review of the facility's Emergency Preparedness (EP) Plan, it was determined the facility failed to develop and maintain an Emergency preparedness communication plan that complies with federal, state, and local laws, affecting the entire facility. Findings include: 1. Interview and documentation review on February 6, 2025, at 9:00 a.m., revealed the EP Plan lacked a communication plan that complies with local, state and federal laws. Interview with the Facility Administrator and Maintenance Director on February 6, 2025, at 1:00 p.m., confirmed the EP Plan lacked a communication plan.	E 0029		

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SQUIRREL HILL WELLNESS AND REHABILITATION CENTER	**2025 WIGHTMAN STREET PITTSBURGH, PA 15217**
STATE LICENSE NUMBER: **231602**	

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E 0029 SS=F	Continued from page 11	E 0029		
E 0030 SS=C	483.73(c)(1) Names and Contact Information §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers.	E 0030	Facility emergency preparedness plan will be updated by 3/21/2025 for accurate names and contact information for staff and resident physicians. A review of the staff and resident physicians will be conducted monthly by the Maintenance director or designee. Findings will be reported to the Quality Assurance and Performance Improvement committee meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/21/2025**

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E 0030 SS=C	Continued from page 12 *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff.	E 0030		

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E 0030 SS=C	Continued from page 13 (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by:	E 0030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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E 0030 SS=C	Continued from page 14 Based on a review of the facility's Emergency Preparedness (EP) Plan, it was determined the facility failed to include names and contact information. Findings include: 1. Interview and documentation review of the facility EP plan on February 6, 2025, at 9:15 a.m., revealed the EP Plan did not include updated and accurate names and contact information for (i) Staff and (ii) Residents physicians. Interview with the Facility Administrator and Maintenance Director on February 6, 2025, at 1:00 p.m., confirmed the listed EP plan deficiency.	E 0030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395028	A. BLDG: __--_____ B. WING: _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SQUIRREL HILL WELLNESS AND REHABILITATION CENTER STATE LICENSE NUMBER: **231602**	**2025 WIGHTMAN STREET PITTSBURGH, PA 15217**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
E 0036 SS=F	483.73(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The	E 0036	Facility trained staff on emergency procedures and tested staff on emergency procedures on March 21,2025 Review of training and testing will be done on an annual basis by Administrator of designee. Findings will be reported to the Quality Assurance and Performance Improvement committee meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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STATE LICENSE NUMBER: **231602**	

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E 0036 SS=F	Continued from page 16 ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by:	E 0036		

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E 0036 SS=F	Continued from page 17 Based on a review of the facility's Emergency Preparedness (EP) Plan, it was determined the facility failed to fully develop and maintain an EP program for training and testing staff. Findings include: 1. Interview and documentation review on February 6, 2025, at 9:10 a.m., revealed the facility's EP training and testing policy failed to indicate what type and recurrence of training and testing is required to demonstrate staff knowledge of emergency procedures. Interview with the Facility Administrator and Maintenance Director on February 6, 2025, at 1:00 p.m., confirmed the facility's EP plan does not include training and testing requirements.	E 0036		

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E 0037 SS=C	483.73(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement,	E 0037	Facility will review new hire training and annual training to include Emergency Preparedness. Annual training for emergency preparedness will be completed by March 3/21/2025. A monthly audit of new hire training courses on emergency preparedness will be completed by the Administrator or designee for completion. On an annual basis, an audit will be conducted by the Administrator or designee for completion of the emergency preparedness training. Findings will be reported to the Quality Assurance and Performance Improvement committee meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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E 0037 SS=C	Continued from page 19 consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.	E 0037		

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E 0037 SS=C	Continued from page 20 *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures.	E 0037		

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E 0037 SS=C	Continued from page 21 *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected	E 0037		

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E 0037 SS=C	Continued from page 22 roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by:	E 0037		

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E 0037 SS=C	Continued from page 23 Based on a review of the facilities Emergency Preparedness (EP) Plan, it was determined the facility failed to maintain documentation of staff EP training and testing. Findings include: 1. Interview and documentation review on February 6, 2025, at 9:20 a.m., revealed the facility lacked documentation of initial and annual training for all new and existing staff. Interview with the Facility Administrator and Maintenance Director on February 6, 2025, at 1:00 p.m., confirmed the training documentation was not maintained.	E 0037		

Certified End Page

SQUIRREL HILL WELLNESS AND REHABILITATION CENTER

STATE LICENSE NUMBER: 231602

SURVEY EXIT DATE: 02/06/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0000	INITIAL COMMENT Facility ID# 231602 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on February 6, 2025, it was determined that Squirrel Hill Wellness and Rehabilitation Center was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is an eight-story, Type II (222), fire resistive building, without a basement, that is fully sprinklered.	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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K 0311 SS=E	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by:	K 0311	Unsealed openings on floors 5 and 7 will be repaired by 3/21/2025. House audit will be completed by Maintenance Director or designee on unsealed openings. The administrator or designee will reeducate Maintenance director on unsealed openings -K311. Identified rooms will be inspected for new openings monthly by the Maintenance Director or designee. Findings will be reported to Quality Assurance and Performance Improvement committee meetings.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0311 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain vertical opening enclosures in one instance, affecting two of 12 smoke compartments. Findings include: 1. Observation on February 6, 2025, between 11:08 a.m. and 11:55 a.m., revealed that floors five and seven (unoccupied), had multiple unsealed openings in a bathroom pipe chase wall, for work being done to replace a leaking drain pipe. Interview with the Facility Administrator and Maintenance Director on February 6, 2025, at 1:00 p.m., confirmed the vertical opening enclosure deficiency.	K 0311		

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K 0324 SS=D	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by:	K 0324	Kitchen Semiannual fire suppression was completed on February 5th, 2025. Semiannual kitchen hood cleaning was competed on February 17, 2025. The administrator or designee will reeducate Maintenance director on cooking facilities -K324.Both inspections will be audited by Maintenance Director or designee for timely completion on a Semiannual basis. Findings will be reported to Quality Assurance and Performance Improvement committee meetings.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0324 SS=D	Continued from page 4 Based on observation, document review, and interview, it was determined the facility failed to maintain cooking facilities in two instances, affecting one of 12 smoke compartments. Findings include: 1. Observation and document review on February 6, 2025, revealed the facility lacked documentation for the following cooking facility inspections and testing: a) 8:55 a.m., a semiannual kitchen fire suppression system inspection, due in August 2024; b) 8:57 a.m., a semiannual hood cleaning and inspection, due in January 2025. Interview with the Facility Administrator and Maintenance Director on February 6, 2025, at 8:57 a.m., confirmed the cooking facility deficiencies listed above.	K 0324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395028	A. BLDG: __01_____ B. WING: _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SQUIRREL HILL WELLNESS AND REHABILITATION CENTER	**2025 WIGHTMAN STREET PITTSBURGH, PA 15217**
STATE LICENSE NUMBER: **231602**	

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K 0324 SS=D	Continued from page 5	K 0324		
K 0345 SS=F	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 0345	Fire panel repairs will be completed by 3/21/2025 by a contracted vendor. Fire panel will be inspected weekly for 4 weeks by Maintenance Director or designee then monthly to see if there are any troubles in the system. The administrator or designee will reeducate Maintenance director on Fire Alarm System -K324. Findings will be reported to the Quality Assurance and Performance Improvement committee meetings.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0345 SS=F	Continued from page 6 Based on documentation review, observation, and interview, it was determined the facility failed to maintain the fire alarm system in one instance, affecting the entire facility Findings Include: 1. Review of documentation and observation on February 6, 2025, at 8:30 a.m., revealed multiple unresolved trouble codes on the main fire alarm control panel for the facility. Interview with the Facility Administrator and Maintenance Director on February 6, 2025, at 1:00 p.m., confirmed the fire alarm system deficiency.	K 0345		
K 0353 SS=F		K 0353		

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K 0353 SS=F	Continued from page 7 NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	Ceiling tiles identified will be replaced by 3/21/2025. House audit for ceiling tiles was completed on February 28th, 2025. Monthly inspection of the ceiling tiles will be conducted by the Maintenance Director or designee. Quarterly and Semiannual sprinkler inspections will be conducted by 3/21/2025. The administrator or designee will reeducate Maintenance director on Sprinkler System – Testing and Maintenance -K353. Findings of sprinkler inspection and ceiling tile audit will be reported to the Quality Assurance and Performance Improvement committee meetings.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0353 SS=F	Continued from page 8 Based on document review, observation, and interview, it was determined the facility failed to maintain the automatic sprinkler system in four instances, affecting the entire building. Findings include: 1. Document review and observation on February 6, 2025, revealed the following automatic sprinkler system deficiencies: a) 8:45 a.m., the facility lacked documentation for quarterly/semiannual sprinkler inspections, other than one completed in October 2024; b) 9:33 a.m., there were four missing ceiling tiles in the Rehabilitation Room on the third floor, which could affect operation of the automatic sprinkler system; c) 10:00 a.m., there was a missing ceiling tile in the maintenance supervisor office; d) 10:05 a.m., there were four missing ceiling tiles above the Nurses Station on the seventh floor (restricted floor).	K 0353		

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K 0353 SS=F	Continued from page 9 Interview with Facility Administrator and Maintenance Director on February 6, 2025, at 1:00 p.m., confirmed the automatic sprinkler system deficiencies listed above.	K 0353		
K 0363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices	K 0363	Identified doors will be fixed to latch by 3/21/2025. House audit was completed for fully closure and latching doors. 1 floor of doors will be audited per week for closure and latching for 4 weeks then monthly by the Maintenance Director or designee. The administrator or designee will reeducate Maintenance director on Proper latching corridor doors -K363. Results will be reported to Quality Assurance and Performance Improvement committee meetings.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0363 SS=E	Continued from page 10 that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	K 0363		

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K 0363 SS=E	Continued from page 11 Based on observation and interview, it was determined the facility failed to maintain corridor doors in four instances, affecting two of 12 smoke compartments. Findings include: 1. Observation on February 6, 2025, revealed the following corridor door deficiencies: a) 8:40 a.m., the door to the dining room on the eighth floor was held open with rubber stoppers; b) 9:45 a.m., the door to Room 624, on the sixth floor, failed to latch when tested; c) 10:15 a.m, the door to Room 609, on the sixth floor, failed to latch when tested; d) 11:20 a.m., the door to Room 302, failed to fully close and latch when tested. Interview with the Facility Administrator and Maintenance Director on February 6, 2025, at 1:00 p.m., confirmed the corridor door deficiencies listed above.	K 0363		

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K 0363 SS=E	Continued from page 12	K 0363		
K 0374 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by:	K 0374	Smoke barrier doors will be replaced by 3/21/2025. House audit was completed to ensure that no other smoke barrier doors need to be replaced. Monthly audit of smoke doors conducted by the Maintenance Director or designee. The administrator or designee will reeducate Maintenance director on Smoke Barrier doors -K374. Results will be reported to Quality Assurance and Performance Improvement committee meetings.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0374 SS=E	Continued from page 13 Based on observation and interview, it was determined the facility failed to maintain smoke barrier doors in one instance, affecting two of twelve smoke compartments. Findings include: 1. Observation on February 6, 2025, at 10:30 a.m., revealed the smoke barrier doors near the kitchen on the eighth floor were removed. Interview with the Facility Administrator and Maintenance Director on February 6, 2025, at 1:00 p.m., confirmed the eighth floor smoke barrier doors were not present, making the smoke wall incomplete.	K 0374		
K 0761 SS=F		K 0761		

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K 0761 SS=F	Continued from page 14 NFPA 101 Maintenance, Inspection & Testing - Doors Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by:	K 0761	Annual fire door assembly was completed on February 21st, 2025. The administrator or designee will reeducate Maintenance director on Annual Fire Door Inspection -K761. The annual inspection of this audit will be conducted by the Maintenance Director or designee and reported to Quality Assurance and Performance Improvement committee meetings.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0761 SS=F	Continued from page 15 Based on documentation review and interview, it was determined the facility failed to perform the required annual fire door assembly inspection, affecting the entire facility. Findings include: 1. Review of documentation on February 6, 2025, at 9:30 a.m., revealed the facility lacked documentation for an annual fire door assembly inspection. Interview with the Facility Administrator and Maintenance Director on February 6, 2025, at 9:30 a.m., confirmed the annual fire door assembly inspection documentation was not available at the time of the survey.	K 0761		
K 0911 SS=D		K 0911		

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K 0911 SS=D	Continued from page 16 NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0911	Electrical junction box was covered on February 14th, 2025. House audit was completed on open electrical junction boxes. The administrator or designee will reeducate Maintenance director on Open electrical junction boxes -K911. Monthly inspection of Housekeeping/Maintenance Closets will be completed by the Maintenance Director or designee. Findings will be reported to Quality Assurance and Performance Improvement committee meetings.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0911 SS=D	Continued from page 17 Based on observation and interview, it was determined the facility failed to maintain electrical wiring in one instance, in one of over 60 rooms inspected. Installation shall be in accordance with NFPA 70, National Electric Code NFPA 101, 19.5.1.1. Findings include: 1. Observation on February 6, 2025, at 10:40 a.m., revealed the cover was missing from an electrical junction box, leaving the electrical wiring exposed, in the Housekeeping/Maintenance closet on the fourth floor. Interview with the Facility Administrator and Maintenance Director on February 6, 2025, at 1:00 p.m., confirmed the listed electrical wiring deficiency.	K 0911		

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K 0918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918	Identified generator tests 1. Annual 90-minute load bank test 2. Triennial 4-hour load bank test 3. Annual preventative maintenance and inspection 4. The annual fuel quality test will be completed by 3/21/2025. The administrator or designee will reeducate the Maintenance director on Electrical Systems – Generator -K918. Tests will be placed on an annual/triennial schedule by the Maintenance Director or designee. Results will be reported to the Quality Assurance and Performance Improvement committee meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0918 SS=F	Continued from page 19	K 0918		

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SQUIRREL HILL WELLNESS AND REHABILITATION CENTER STATE LICENSE NUMBER: **231602**	**2025 WIGHTMAN STREET PITTSBURGH, PA 15217**

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K 0918 SS=F	Continued from page 20 Based on documentation review and interview, it was determined the facility failed lacked documentation for emergency generator maintenance and testing due to be performed in the last 12 or 36 months, in four instances, affecting the entire facility. Findings include: 1. Review of documentation on February 6, 2025, revealed the facility lacked documentation of the following tests and inspections, required to be performed in the last 12 or 36 months: a) 9:00 a.m., the annual 90-minute load bank test; b) 9:15 a.m., the triennial four-hour load test; c) 9:20 a.m., the annual preventative maintenance and inspection; d) 9:25 a.m., the annual fuel quality test. Interview with the Facility Administrator and Maintenance Director, on February 6, 2025, at 9:25 a.m., confirmed the required annual and triennial	K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395028	A. BLDG: 01 B. WING:	02/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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K 0918 SS=F	Continued from page 21 generator testing documentation listed above, was not available at the time of the survey.	K 0918		
K 0920 SS=C	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	K 0920	Power strip was removed from office on February 18th, 2025. The administrator or designee will reeducate Maintenance director on power strips -K920. Inspection of the offices with refrigerators is completed monthly by the Maintenance Director or designee. Findings will be reported to the Quality Assurance and Performance Improvement committee meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395028	A. BLDG: __01_____ B. WING: _____	02/06/2025

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K 0920 SS=C	Continued from page 22 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain electrical wiring systems and equipment in one instance, in one of over 60 rooms inspected. Findings include: 1. Observation on February 6, 2025, at 11:10 a.m., revealed a refrigerator plugged into a power strip in Nursing Office Room 805. Interview with the Facility Administrator and Maintenance Director on February 6, 2025, at 1:00 p.m., confirmed the misuse of a power strip used to power a refrigerator.	K 0920		

Certified End Page

SQUIRREL HILL WELLNESS AND REHABILITATION CENTER

STATE LICENSE NUMBER: 231602

SURVEY EXIT DATE: 02/06/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY