

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
STATE LICENSE NUMBER: <b>231602</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0000	INITIAL COMMENT	F 0000		
F 0550	Based on a Medicare/Medicaid Recertification survey, State Licensure, Civil Rights Compliance, and an Abbreviated Survey in response to a complaint, completed February 14, 2025, it was determined that Squirrel Hill Wellness and Rehabilitation Center, was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey.	F 0550		
SS=D				

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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F 0550  SS=D	Continued from page 1  483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights  §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.  §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.  §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.  §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.  §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 0550	A meeting regarding the facility's Non-Smoking Policy was conducted with residents #R11, R19, R28 and R53 (the "grandfathered residents"), each of whom had signed a smoking agreement prior to the non-smoking policy going into effect on February 5, 2025. The information discussed at that meeting included smoking times and rules for these grandfathered residents. The information was incorporated into the plan of care for these residents.  The facility has determined that all residents have the potential to be affected. New residents are informed about the facility's Non-Smoking Policy prior to admission and are offered smoking cessation products.  In-service education programs were conducted separately with licensed and non-licensed staff by the Director of Nursing Services (DON), or designee. In-service education regarding the Non-Smoking Policy included the grandfathered residents who are permitted to smoke.	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/06/2025</b>

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F 0550  SS=D	Continued from page 2  §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.  This REQUIREMENT is not met as evidenced by:	F 0550	The Director of Nursing Services (DON), or designee, will conduct random observations to ensure that the smoking rights of the grandfathered residents are being met. Such observations will take place once per week for four weeks, then bi-weekly for one month, then monthly for one month.  This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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F 0550  SS=D	Continued from page 3  Based on observations, review of facility policies and documentation, clinical record review and interviews with residents and staff, it was determined that the facility failed to honor a resident's right to smoke, for 4 of 10 residents reviewed (Residents R11, R19, R28, and R53).  Findings include:  A review of the facility "Smoking Policy" dated 10/20/24, indicated the facility follows a supervised smoking policy and smoking is permitted in designated areas.  A review of the facility policy "Smoke Free Facility" dated 2/5/25, indicated that smoking is prohibited in all areas of the facility and facility grounds."  A review of Resident R11's clinical record indicated the resident was admitted to the facility on 5/9/24 with diagnoses that included anxiety, depression, and hypertension (high blood pressure). The resident is alert and able to make needs known.	F 0550		

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F 0550  SS=D	Continued from page 4  A review of Resident R11's care plan dated 1/15/25, indicated the resident has history of smoking in the community and wishes to continue smoking.  A review of a social service progress note dated 2/4/25, indicated Resident R11 was informed that smoking is no longer permitted on the premises. The resident declined to have a smoking patch and wants to transfer to a smoking facility.  During an interview on 2/12/25, at 10:30 a.m. Resident R11 stated "I want to smoke, and I don't want the patch, if I can't smoke here, I want transferred to a place I can smoke. I am an addict who quit drugs, I shouldn't have to give up my cigarettes".  A review of Resident R19's clinical record indicated the resident was admitted to the facility on 1/28/15 with diagnoses that included paranoid schizophrenia (a type of psychosis where the mind does not agree	F 0550		

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F 0550  SS=D	Continued from page 5  with reality), diabetes, and tobacco use. The resident is alert and able to make needs known.  A review of Resident R19's care plan dated 6/24/24, indicated the resident has history of smoking in the community and wishes to continue smoking.  A review of a social service progress note dated 2/3/25, indicated Resident R19 was informed that smoking is no longer permitted on the premises. The resident declined to have a smoking patch or be referred to another smoking facility.  During an interview on 2/14/25, at 9:35 a.m. Resident R19 stated "I want to smoke, and I don't want the patch or to go anywhere else."  A review of Resident R28's clinical record indicated the resident was admitted to the facility on 6/14/19 with diagnoses that included heart failure, and nicotine dependence. The resident is alert and able to make needs known.	F 0550		

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F 0550  SS=D	<p>Continued from page 6</p> <p>A review of Resident R28's care plan dated 11/1/24, indicated the resident has history of smoking in the community and wishes to continue smoking.</p> <p>A review of a social service progress note dated 2/4/25, indicated Resident R28 was informed that smoking is no longer permitted on the premises. The resident declined to have a smoking patch and wanted referred to another smoking facility.</p> <p>During an interview on 2/11/24, at 10:30 a.m. (resident still not transferred to another smoking facility) Resident R28 stated "I don't want the patch, I told them if I can't smoke here, I want transferred to a place I can smoke. They said someone would come in and get me moved, no one has come in." Resident 28 repeatedly stated she does not want the patch and wants to go anywhere she can smoke right now.</p> <p>A review of Resident R53's clinical record indicated the resident was admitted to the facility on 10/4/23</p>	F 0550		

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F 0550  SS=D	Continued from page 7  with diagnoses that included heart failure, diabetes, and high blood pressure. The resident is alert and able to make needs known.  A review of Resident R53's Admission Agreement signed 6/12/23, indicated the facility is a smoking facility.  A review of Resident R53's care plan dated 12/8/24, indicated the resident has history of smoking in the community and wishes to continue smoking.  A review of a social service progress note dated 2/3/25, indicated Resident R53 was informed that smoking is no longer permitted on the premises. The resident declined to have a smoking patch and wanted referred to another smoking facility.  During an interview on 2/14/25, at 9:45 a.m. Resident R53 stated "I want to smoke, and I don't want the patch, and I really do not want to go anywhere else."	F 0550		

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F 0550  SS=D	Continued from page 8  During an interview on 2/14/25 at 1:00 p.m. the Director of Nursing confirmed the above findings and that the facility changed their smoking policy on 2/5/25, and Resident's R11, R19, R28, and R53's right to smoke was no longer honored at the facility.  28 Pa. Code 201.29(a)(j) Resident rights.  28 Pa. Code 209.3(a) Smoking.	F 0550		
F 0565  SS=D		F 0565		

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F 0565  SS=D	<p>Continued from page 9</p> <p>483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response</p> <p>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.</p> <p>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.</p> <p>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.</p> <p>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.</p> <p>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.</p> <p>(A) The facility must be able to demonstrate their response and rationale for such response.</p> <p>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.</p> <p>§483.10(f)(6) The resident has a right to participate in family groups.</p>	F 0565	<p>The Resident Council will be interviewed to see when they would like to have their meetings.</p> <p>No residents were affected by not having 3 months of resident council.</p> <p>Resident Council education was given to the Activity Director.</p> <p>A monthly review of resident council minutes will be completed by Administrator of designee.</p> <p>Findings will be discussed at quality assurance and process improvement meetings.</p>	<p>Completion Date: <b>03/28/2025</b></p> <p>Status: <b>APPROVED</b></p> <p>Date: <b>03/06/2025</b></p>

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F 0565  SS=D	Continued from page 10  §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.  This REQUIREMENT is not met as evidenced by:	F 0565		

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F 0565  SS=D	Continued from page 11  Based on review of facility policy, facility documentation, resident group and staff interviews, it was determined the facility failed to provide Resident Council the opportunity for meetings for three of twelve months (September 2024, October 2024, and November 2024).  Findings include:  Review of the facility policy titled, "Resident Council Meetings" reviewed 10/20/24, states the council meets at least quarterly but no less than as determined by the group. The Activity Director/designee shall be designated to serve as the group liaison. The designated liaison shall be responsible for providing assistance with facilitating successful group meetings and responding to written requests from the group meetings.  During Resident Group, with four alert and oriented residents and the Ombudsman on 2/11/25, at 10:30 a.m., Residents R5, R26 R28 and R52 indicated some months no meetings were arranged. The	F 0565		

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F 0565  SS=D	Continued from page 12  attendees reported that the activities department had organized the meetings until the activity director and one other activity staff member resigned. Council members reported, now there is only one part time activity aide in the facility.  During an interview on 2/12/25, at 12:00 p.m. the Nursing Home Administrator (NHA) confirmed the facility failed to provide Resident Group the opportunity for meetings for three of twelve months (September 2024, October 2024, and November 2024).  28 Pa. Code: 201.14 (a) Responsibility of licensee.  28 Pa. Code: 201.18 (e)(1)(4) Management.	F 0565		
F 0577  SS=F		F 0577		

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F 0577  SS=F	Continued from page 13  483.10(g)(10)(11) Right to Survey Results/Advocate Agency Info  §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.  §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents.  This REQUIREMENT is not met as evidenced by:	F 0577	No residents were affected by not having access to the survey results.  Previous years surveys have been printed and placed in the survey binders.  The Director of nursing was educated on Access to survey results.  The Director of nursing will audit the binders monthly for up-to-date 2567 information.  Findings will be reported in quality assurance and process improvement meetings.	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/06/2025</b>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0577  SS=F	Continued from page 14  Based on observation and staff interview, it was determined the facility failed to ensure the Department of Health most recent survey results were readily accessible to residents and visitors, for three of three locations (first floor lobby, nursing units fourth, and six floors).  Findings Include:  During an interview on 2/11/25, at 10:30 a.m., the Resident Group, four of four residents agreed that they were unaware of the location of the Department of Health survey results (Residents R5, R26 R28 and R52).  During an observation on 2/12/25, at 9:20 a.m., signage in the lobby, fourth floor and sixth floor read "survey results can be found on the 1st, 4th, and 6th floors" (the public entry and resident care areas).  During an observation on 2/12/25, at 9:20 a.m. in the lobby, no survey result book could be located.	F 0577		

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F 0577  SS=F	Continued from page 15  During an observation on 2/12/25, at 9:22 a.m. on the fourth floor, the survey result book was located behind empty folders and contained survey results from 2023. The prior survey date for this facility was on 2/12/24.  During an observation on 2/12/25, at 9:24 a.m. on the sixth floor, no survey result book could be located.  During an interview on 2/12/25, at 9:25 a.m. the Director of Nursing (DON) confirmed the facility failed to ensure the Department of Health most recent survey results were readily accessible to residents and visitors for three of three locations, (first floor lobby, nursing units fourth, and six floors).  28 Pa. Code 201.14(a) Responsibility of licensee.	F 0577		
F 0578  SS=E		F 0578		

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F 0578  SS=E	Continued from page 16  483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir  §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.  §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.  §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	Residents5, R11, R35, R41, R45, R52, and R55 have been provided the opportunity to formulate an advance directive. Residents electing to execute advance directives have been provided assistance. The facility has determined that current residents have the potential to be affected. Audit completed on current residents to ensure each has been given the opportunity to formulate an advance directive. Facility reviewed with each resident their decision regarding advance directive status and provisions. The Nursing Home Administrator, or designee, has re-educated the interdisciplinary team members responsible for advance directives on the facility's "Advance Directives". The facility will offer residents on admission/readmission the opportunity and assistance to formulate an advance directive. Facility will review during annual care conference with resident and responsible party the decisions made regarding advance directives.	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/06/2025</b>

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F 0578  SS=E	Continued from page 17  directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.  This REQUIREMENT is not met as evidenced by:	F 0578	The Director of Social Services, or designee will review care conference summary notes to ensure each resident has been provided the opportunity to formulate an advance directive and review any previously made decisions regarding advance directives weekly for 2 months. Results of audits will be reviewed by Quality Assurance Committee quarterly until committee determines consistent substantial compliance.	

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F 0578  SS=E	Continued from page 18  Based on review of the facility policy and clinical records and staff interview, it was determined that the facility failed to provide the opportunity to formulate an advance directive (written instructions for when the individual is incapacitated) or conduct periodic review of instructions, for seven of the twenty-two residents reviewed (Resident R5, R11, R35, R41 R45, R52, and R55).  Findings Include:  A review of the facility policy "Resident Rights Regarding Treatment and Advanced Directives" last reviewed 10/20/24, indicated it's the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate and advance directive. Decisions regarding advanced directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions.	F 0578		

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F 0578  SS=E	Continued from page 19  Review of the Resident Assessment Instrument 3.0 User's Manual, effective October 2023, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:  13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment  Review of the clinical record indicated Resident R5 was originally admitted to the facility on 3/13/02.  Review of Resident R5's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/17/24, indicated diagnoses of Anxiety, depression, and dementia, a BIMS of 15.  A review of the clinical record failed to reveal an advance directive, evidence that a periodic advanced directive review occurred or documentation that Resident R5 was given the	F 0578		

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F 0578  SS=E	Continued from page 20  opportunity to formulate an Advanced Directive.  Review of the clinical record indicated Resident R11 was admitted to the facility on 5/9/24.  Review of Resident R11's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/16/24, indicated diagnoses of Anxiety, depression, and hypertension (high blood pressure), a BIMS of 15.  A review of the clinical record failed to reveal an advance directive, evidence that a periodic advanced directive review occurred or documentation that Resident R11 was given the opportunity to formulate an Advanced Directive.  Review of the clinical record indicated Resident R35 was admitted to the facility on 10/16/23.  Review of Resident R35's MDS dated 9/4/24, indicated diagnoses of Anxiety, depression, and coronary artery disease (heart disease), a BIMS of	F 0578		

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F 0578  SS=E	Continued from page 21  15.  A review of the clinical record failed to reveal an advance directive, evidence that a periodic advanced directive review occurred or documentation that Resident R35 was given the opportunity to formulate an Advanced Directive.  Review of the clinical record indicated Resident R41 was admitted to the facility on 4/11/19.  Review of Resident R41's MDS dated 8/5/24, indicated diagnoses of stroke, depression, and dementia, a BIMS of 7.  A review of the clinical record failed to reveal an advance directive, evidence that a periodic advanced directive review occurred or documentation that Resident R41 was given the opportunity to formulate an Advanced Directive.  Review of the clinical record indicated Resident R45 was admitted to the facility on 1/13/25.	F 0578		

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F 0578  SS=E	Continued from page 22  Review of Resident R45's MDS dated 1/17/25, indicated diagnoses of left shoulder fracture, depression, and dementia, a BIMS of 8.  A review of the clinical record failed to reveal an advance directive, evidence that a periodic advanced directive review occurred or documentation that Resident R45 was given the opportunity to formulate an Advanced Directive. Review of the clinical record indicated Resident R52 was originally admitted to the facility on 1/2/24.  Review of Resident R52's MDS dated 11/13/24, indicated diagnoses of coronary artery disease (heart disease), dementia, depression, a BIMS of 15.  A review of the clinical record failed to reveal an advance directive, evidence that a periodic advanced directive review occurred or documentation that Resident R52 was given the opportunity to formulate an Advanced Directive.	F 0578		

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F 0578  SS=E	Continued from page 23  Review of the clinical record indicated Resident R55 was admitted to the facility on 8/20/24.  Review of Resident R55's MDS dated 1/19/25, indicated diagnoses of schizoaffective disorder (mental illness affects thoughts, mood and behavior), diverticulitis of large intestine with perforation and abscess (inflammation of the colon), and hypertension (high blood pressure), a BIMS of 15.  A review of the clinical record failed to reveal an advance directive, evidence that a periodic advanced directive review occurred or documentation that Resident R55 was given the opportunity to formulate an Advanced Directive.  During an interview on 2/11/25 at 8:00 a.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to provide the opportunity to formulate an advance directive or conduct periodic review of instructions, for seven of the twenty-two residents reviewed (Resident R5, R11, R35, R41	F 0578		

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F 0578  SS=E	Continued from page 24  R45, R52, and R55).  28 Pa. Code: 201.29(b)(d)(j) Resident rights.	F 0578		
F 0582  SS=E		F 0582		

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F 0582  SS=E	Continued from page 25  483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice  §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.  §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation	F 0582	Resident 217 and 218 have been discharged on 10/22/2024 and 8/2/2024 respectively  The facility has determined that residents with a qualifying hospital stay and Medicare Part A benefit days available have the potential to be affected. An audit was conducted on current residents who were admitted in the past six months, and corrective actions were completed on 3/21/2025  The Administrator educated the following personnel on the facility's Advance Beneficiary Notices policy: Business Office Manager, Social Services Director and Assistant, MDS Coordinator, Director of Nursing, and Rehabilitation Program Manager. Copies of the relevant forms were placed in a binder in the offices of the Business Office Manager and Social Services Director  The Social Service Director, or designee, will conduct a random	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

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F 0582  SS=E	Continued from page 26  of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.  This REQUIREMENT is not met as evidenced by:	F 0582	audit of five (5) residents weekly for four (4) consecutive weeks to verify that notices were issued timely  This plan of correction will be monitored at the Quality Assurance meeting until such time consistent substantial compliance has been met	

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F 0582  SS=E	Continued from page 27  Based on review of facility policy, facility documents, and staff interviews, it was determined that the facility failed to provide in a timely manner, notice of Medicare non coverage (payment) for two of two residents (Resident R217 and R218).  Findings include:  Review of CMS guidelines, Medicare provider or health plan must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services. The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. The Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage, (SNF ABN) must be issued to Medicare Fee -for-Service (original Medicare) beneficiaries who are receiving care in a Skilled Nursing Facility (SNF) when: Medicare is	F 0582		

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F 0582  SS=E	Continued from page 28  expected to deny coverage and when the SNF wants to charge the beneficiary for the non-covered services.  A review of the facility policy "Advance Beneficiary Notices", last reviewed 10/20/24, indicated the facility assures appropriate Advance Beneficiary Notices are issued in accordance with CMS guidelines.  A review of the list of Medicare residents who were discharged from a Medicare Part A stay with benefit days remaining, provided by the facility on 2/11/25, included Residents R217 and R218.  A review of the SNF ABN form for Residents R218 indicated payment for skilled nursing services would end on 8/2/24. The facility failed to provide the document for Resident R218 and failed to provide the resident time to appeal.  A review of the SNF ABN form for Residents R217 indicated payment for skilled nursing services	F 0582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
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F 0582  SS=E	<p>Continued from page 29</p> <p>would end on 10/21/24. The facility failed to provide the document for Resident R 217 and failed to provide the resident time to appeal.</p> <p>A review of the facility NOMNC form indicated that the resident has a right to appeal non-payment of services, your request must be made no later than noon of the day before the effective date of non-coverage.</p> <p>A review of the NOMNC form for Resident R217 indicated payment for skilled nursing services will end 10/21/24. The facility failed to provide the document for Resident R 217 and failed to provide the resident time to appeal.</p> <p>During an interview on 2/11/25, at 10:20 a.m. the NHA confirmed that the facility was unable to provide the NOMNC form for Resident R217 and the SNF ABN for Residents R217 and R218.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p>	F 0582		

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F 0582  SS=E	Continued from page 30  28 Pa. Code 201.18(b)(2) Management.	F 0582		
F 0584  SS=E	28 Pa. Code 201.29(a): Resident rights. 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.  The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 0584	By March 27th, 2025, the Maintenance Supervisor fixed the identified area noted in the 2567  All residents have the potential to be affected by this practice  The maintenance director will complete a house audit to ensure no other areas of the facility are affected  The Maintenance director will perform room inspections monthly and as needed to identify and address any needed repairs.&#8239; Staff will report any identified concerns to the maintenance supervisor upon observation  Results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
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F 0584  SS=E	Continued from page 31  §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);  §483.10(i)(5) Adequate and comfortable lighting levels in all areas;  §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and  §483.10(i)(7) For the maintenance of comfortable sound levels.  This REQUIREMENT is not met as evidenced by:	F 0584		

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F 0584  SS=E	Continued from page 32  Based on policy review and observations and staff interviews it was determined that the facility failed to maintain a homelike environment throughout the facility (resident rooms, dining rooms and hallways) for three of three nursing units. (4th, 5th, and 6th floor nursing units)  Findings include:  A review of the facility policy "Safe and Homelike Environment" dated 10/20/24, indicated the facility will provide a safe, clean, comfortable, and homelike environment.  During an observation of the facility on 2/14/25, at 9:30 a.m., the following was revealed:  * Resident room 409 W (window) air condition/heating unit had broken vents and dusty debris and trash particles inside the unit. The wall next to the bathroom entrance had missing molding and holes around the night light.	F 0584		

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F 0584  SS=E	Continued from page 33  * Resident room 410 W air condition/heating unit had broken vents and dusty debris and trash particles inside the unit.  * Resident room 421 W air condition/heating unit had broken vents and dusty debris and trash particles inside the unit.  * Resident room 423 W air condition/heating unit had broken vents and dusty debris and trash particles inside the unit.  * Resident room 424 W air condition/heating unit had broken vents and dusty white debris and trash particles inside the unit.  * Resident rooms 401 and 425 had molding around the perimeter of the rooms with exposed tubing and black cables that lead into the bathroom sink drainage connection and not in use.  * Dining rooms on the 4th, 5th, and 6th floors had brown vinyl flooring that was lifting up and had worn	F 0584		

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F 0584  SS=E	Continued from page 34  black holes throughout.  * Fifth Floor nursing units rooms 511, 512, and multiple rooms with no room numbers had walls with holes and scratches behind the beds.  *Sixth Floor nursing unit room 607 had holes in the wall and scratches behind the bed.  During an interview on 2/14/25, at 10:30 a.m., the Director of Nursing confirmed that the facility failed to maintain the facility in a homelike environment.  Pa Code: 207.2 (a) Administrator's responsibility	F 0584		
F 0585  SS=D		F 0585		

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F 0585  SS=D	Continued from page 35  483.10(j)(1)-(4) Grievances  §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.  §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.  §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.  §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 0585	No residents were affected by not having the forms and box accessible due to the trash in front of the box and no forms present.  This does present a potential and the Grievance Officer was educated on the Grievance policy by the NHA and or designee  Trash bins removed and forms added  Grievance officer or designee will audit forms being present and no obstructions 3 times a week for 4 weeks in identified locations.  Results will be reported to the quality improvement and process improvement	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

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F 0585  SS=D	Continued from page 36  can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the	F 0585		

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F 0585  SS=D	Continued from page 37  date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.  This REQUIREMENT is not met as evidenced by:	F 0585		

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F 0585  SS=D	Continued from page 38  Based on review of facility policy, observations, and resident and staff interviews, it was determined that the facility failed to provide and make accessible grievance forms to residents and visitors on one of two nursing units (fourth floor) and failed to make the grievance box accessible on one of two nursing units (fourth floor).  Findings include:  A review of the facility policy "Resident and Family Grievance" reviewed 10/20/24, indicated the facility utilizes a grievance form to identify concerns and for tracking.  During an observation on 2/12/25, at 9:25 a.m. revealed the grievance box and forms were not accessible due to a trash bin placed in front of the grievance box on the fourth-floor nursing unit.  During an observation on 2/12/25, at 9:25 a.m. revealed the grievance forms were not present on the fourth-floor nursing unit.	F 0585		

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F 0585  SS=D	Continued from page 39  During an interview on 2/12/25, at 9:25 a.m. The Director of Nursing confirmed the facility failed to provide and make accessible grievance forms to residents and visitors on one of two nursing units (fourth floor) and failed to make the grievance box accessible on one of two nursing units (fourth floor).  28 PA Code: 201.18(e)(4) Management.  28 PA Code: 201.29(a)(b)(c) Resident rights.	F 0585		
F 0610  SS=D		F 0610		

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F 0610  SS=D	Continued from page 40  483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.  This REQUIREMENT is not met as evidenced by:	F 0610	Resident R46 was discharged to another facility and unable to be interviewed.  The facility has determined that all residents have the potential to be affected if allegations of abuse are not investigated in a timely manner.  An in-service education program was conducted by the Director of Nursing Services and the Administrator with direct care staff addressing circumstances that require reporting for timely investigations, and their responsibilities related to investigations. Policy and education on Resident Abuse Prevention and Reporting  The Director of Nursing Services, or designee, will review nursing notes five days per week to identify any allegations of abuse weekly for four (4) consecutive weeks. These residents will be assessed and interviewed to ensure that any injuries are identified, properly	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

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F 0610  SS=D	Continued from page 41	F 0610	investigated, and reported to the appropriate people. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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F 0610  SS=D	Continued from page 42  Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to make certain allegations of abuse, neglect, exploitation, or mistreatment are thoroughly investigated for one of two residents reviewed. (Resident R46).  Findings include:  A review of the facility "Abuse, Neglect, and Exploitation" policy dated 10/20/24, indicated that the facility will provide complete and through documentation of the investigation. Identify and interviewing all involved persons, including the alleged victim, alleged perpetrator, witness and others who might have knowledge of the allegations.  A review of Resident R46's admission record indicated the resident was admitted on 5/8/24. Resident R46 was transferred to the hospital 2/3/25 for evaluation of a Deep Vein Thrombosis (blood clot).	F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0610  SS=D	Continued from page 43  Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019 indicated that a Brief Interview for Mental Status (BIMS), is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:  13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment  A review of Resident R46 Minimum Data Set assessment (MDS-a periodic assessment of resident care needs) dated 1/23/25, included diagnoses of Cerebrovascular Accident (stroke), anxiety disorder, depression, and chronic osteomyelitis of the left ankle and foot (bone infection). Review of Section C: Cognitive Patterns, Questions C0500 "BIMS Summary Score" revealed Resident R46's score to be "14", intact cognition.  A review of facility submitted documents, indicated Resident R46 and nursing staff, RN Employee E14	F 0610		

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F 0610  SS=D	Continued from page 44  and LPN Employee R15 were giving Resident R46 a hard time when the resident asked why his pain medication was late, an escalation between resident and staff occurred. Reportedly LPN Employee E15 stated "in fact now I am going to make sure you're the last one who gets medication" and Employee E14 was heard saying "let him shit and piss on himself and sit in it". The investigation report indicates the resident (victim) was interviewed, (no resident interview was attached) and the report indicates Resident R46 is not a credible source, referencing residence past behaviors and medical history.  A review of the personnel files indicates that both RN Employee E14 and LPN Employee E15 were terminated from the facility after this event.  There was no documented evidence the facility interviewed Resident R46 for the alleged incident of abuse.  During an interview on 2/12/25, at 11:15 a.m. the	F 0610		

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F 0610  SS=D	Continued from page 45  Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility failed to thoroughly investigate an alleged incident of neglect for one of two residents (Resident R46).  28 Pa Code: 201.14(a)(c)(e) Responsibility of licensee  28 Pa Code: 201.18 (b)(1)(e)(1) Management  28 Pa. Code: 201.20 (b) Staff development.	F 0610		
F 0636  SS=E		F 0636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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F 0636  SS=E	Continued from page 46  483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing  §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning.	F 0636	By time of the annual survey, the MDS Team completed the Comprehensive Assessment for Resident 1, 23, 45, 49, 52, 57, and 58&#8239;  All residents of this facility have the potential to be affected by this practice  A house wide audit was completed to ensure that comprehensive assessments were completed timely  The facility's MDS Team attended an in-service presented by the MDS Nurse Consultant  The Nurse Consultant will review the assessment schedule monthly to ensure timely completion  Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

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F 0636  SS=E	Continued from page 47  (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.  §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b) (2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii) Not less than once every 12 months.  This REQUIREMENT is not met as evidenced by:	F 0636		

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F 0636  SS=E	Continued from page 48  Based on review of the Resident Assessment Instrument User's Manual, clinical records, and staff interview, it was determined that the facility failed to make certain that comprehensive Minimum Data Set (MDS- periodic assessment of resident care needs) assessments were completed in the required time frame for seven of 25 residents (Resident R1, R23, R45, R49, R52, R57, and R58).  Findings include:  The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required MDS assessments, dated October 2024, indicated that an admission MDS assessment was to be completed no later than 14 days following admission (admission date plus 13 calendar days), and annual MDS assessment was to be completed no later than Assessment Reference Date (ARD).  Resident R1 had an ARD of 11/13/24, with an MDS completion date of 11/28/24.	F 0636		

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F 0636  SS=E	Continued from page 49  Resident R23 had an ARD of 1/16/25, with an MDS completion due date of 1/31/25.  Resident R45 had an admission date of 1/13/25, with an MDS completion due date of 1/27/25.  Resident R49 had an ARD of 12/15/24, with an MDS completion date of 1/3/25.  Resident R52 had an ARD of 11/13/24, with an MDS completion date of 11/29/24.  Resident R57 had an admission date of 1/15/25, with an MDS completion due date of 1/30/25.  Resident R58 had an admission date of 1/11/25, with an MDS completion due date of 1/30/25.  During an interview on 2/14/25, at approximately 2:00 p.m. the Nursing Home Administrator and the Director of Nursing were made aware that the facility failed to make certain that MDS assessments	F 0636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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F 0636  SS=E	Continued from page 50  were completed in the required time frame for seven of 25 residents.  28 Pa. Code: 211.5(f) Clinical records.	F 0636		
F 0638  SS=E		F 0638		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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F 0638  SS=E	Continued from page 51  483.20(c) Qrtly Assessment at Least Every 3 Months  §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.  This REQUIREMENT is not met as evidenced by:	F 0638	By the time of the Annual Survey, the MDS Team completed the Quarterly Review for Resident 12, 14, 20, 30, 34, 35, 41, 43, 44, and 55  All residents of this facility have the potential to be affected by this practice  House wide audit was completed to ensure quarterly assessments were done timely  The facility's MDS Team attended an in-service presented by the MDS Nurse Consultant  The Nurse Consultant or designee will review the assessment schedule monthly to ensure timely completion  Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
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F 0638  SS=E	Continued from page 52  Based on review of the Resident Assessment Instrument User's Manual, clinical records, and staff interview, it was determined that the facility failed to make certain that quarterly Minimum Data Set assessments were completed within the required time frame for ten of 51 residents (Resident R12, R14, R20, R30, R34, R35, R41, R43, R44, and R55).  Findings include:  The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated that quarterly MDS assessments were to be completed no later than 14 days after the Assessment Reference Date (ARD).  Resident R12 had an ARD of 12/12/24, with an MDS completion date of 1/3/25.  Resident R14 had an ARD of 12/20/24, with an	F 0638		

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F 0638  SS=E	Continued from page 53  MDS completion date of 1/7/25. Resident R20 had an ARD of 11/14/24, with an MDS completion date of 11/30/24. Resident R30 had an ARD of 12/4/24, with an MDS completion date of 1/3/25. Resident R34 had an ARD of 11/28/24, with an MDS completion date of 1/3/25. Resident R35 had an ARD of 12/5/24, with an MDS completion date of 1/3/25. Resident R41 had an ARD of 12/19/24, with an MDS completion date of 1/3/25. Resident R43 had an ARD of 1/15/25, with an MDS completion date of 1/31/25. Resident R44 had an ARD of 11/14/24, with an MDS completion date of 11/28/24. Resident R55 had an ARD of 12/4/24, with an MDS completion date of 1/3/25.  During an interview on 2/14/25, at approximately 2:00 p.m. the Nursing Home Administrator and the Director of Nursing were made aware that the facility failed to make certain that quarterly MDS assessments were completed in the required time	F 0638		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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F 0638  SS=E	Continued from page 54  frame for six of 25 residents.  28 Pa. Code: 211.5(f) Clinical records.	F 0638		
F 0641  SS=E		F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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F 0641  SS=E	Continued from page 55  483.20(g) Accuracy of Assessments  §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.  This REQUIREMENT is not met as evidenced by:	F 0641	Resident 8, 10, 13, 29, 36, 40, and 54 was reassessed to include Section C and BIMS be conducted.  The facility has determined that all residents have the potential to be affected.  A house audit has been completed to ensure that section C and BIMS were completed appropriately.  An in-service education program was conducted by the Director of Nursing Services or designee with MDS Coordinator(s) and Social Service to addressing the importance of making certain that the comprehensive minimum data set assessments were accurate and fully completed.  The Director of Nursing Services, or designee, will conduct a random audit of five (5) residents per week on their MDS for four (4) consecutive weeks. These residents and their medical records will be assessed to ensure that the Bims	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/06/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
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F 0641  SS=E	Continued from page 56	F 0641	<p>section is completed correctly in the MDS</p> <p>This plan of correction will be monitored at the monthly Quality Assurance meeting until such a time consistent substantial compliance has been met.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
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F 0641  SS=E	Continued from page 57  Based on review of the Resident Assessment Instrument User's Manual and clinical records, and staff interview, it was determined that the facility failed to make certain that comprehensive Minimum Data Set assessments were accurate and fully completed for seven of ten residents (Resident R8, R10, R13, R29, R36, R40, and R54).  Findings include:  The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set Assessments (MDS - periodic assessment of care needs) dated October 2024, indicated that Section C: Cognitive Patterns, Question C0100 "Should Brief Interview for Mental Status Be Conducted?" (BIMS) should be coded as "0" if the resident is rarely/never understood, or it should be coded "1", and the BIMS assessment should be completed if the resident is at least sometimes understood. Section D: Mood, Question D0100 "Should Resident Mood Interview Be Conducted?" should	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
STATE LICENSE NUMBER: <b>231602</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0641  SS=E	Continued from page 58  be coded as "0" if the resident is rarely/never understood, and or it should be coded "1", and the assessment should be completed if the resident is at least sometimes understood.  -Resident R8 had an MDS completed on 1/9/25. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R8 is "sometimes understood." Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R8 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question C0100 indicated that Resident R8 is rarely understood, and the Resident Mood Interview assessment was not completed.  -Resident R10 had an MDS completed on 11/13/24. Review of Section B: Hearing, Speech, and Vision indicated Resident R10 was not in a persistent vegetative state/no discernible consciousness. The remainder of the questions in this section were documented as "Not Assessed." Review of Sections C: Cognitive Patterns and	F 0641		

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F 0641  SS=E	Continued from page 59  Section D: Mood, BIMS and Resident Mood Interview indicated all questions were documented as "Not Assessed."  -Resident R13 had an MDS completed on 11/19/24. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R13 is "understood." Review of Sections C: Cognitive Patterns, Question C0100 indicated the BIMS assessment should be completed. All further questions were documented as "Not Assessed."  -Resident R29 had an MDS completed on 2/4/25. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R29 is "sometimes understood." Review of Sections C: Cognitive Patterns and Section D: Mood, BIMS and Resident Mood Interview indicated all questions were documented as "Not Assessed."  -Resident R36 had an MDS completed on 11/16/24. Review of Section B: Hearing, Speech, and Vision indicated Resident R10 was not in a	F 0641		

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F 0641  SS=E	Continued from page 60  persistent vegetative state/no discernible consciousness. Question B0700: Makes Self Understood was documented as "Not Assessed." Review of Sections C: Cognitive Patterns and Section D: Mood, BIMS and Resident Mood Interview indicated all questions were documented as "Not Assessed."  -Resident R40 had an MDS completed on 1/9/25. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R40 is "understood." Review of Sections C: Cognitive Patterns and Section D: Mood, BIMS and Resident Mood Interview indicated all questions were documented as "Not Assessed."  -Resident R54 had an MDS completed on 2/4/25. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R54 is "understood." Review of Sections C: Cognitive Patterns, Question C0100 indicated the BIMS assessment should be completed. All further questions were documented as "Not Assessed."	F 0641		

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F 0641  SS=E	Continued from page 61  During an interview on 2/14/25, at approximately 12:00 p.m. the Resident Nurse Assessment Coordinator confirmed that the facility failed to make certain that comprehensive Minimum Data Set assessments were accurate and fully completed for seven of ten residents.  28 Pa. Code: 211.5(f) Clinical records.	F 0641		
F 0679  SS=E		F 0679		

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F 0679  SS=E	Continued from page 62  483.24(c)(1) Activities Meet Interest/Needs Each Resident  §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.  This REQUIREMENT is not met as evidenced by:	F 0679	Resident R5, R11, R26, R35, R41, R45, R52, and R 55 were interviewed by Activities Staff to determine activity preferences. Structured activities were placed on the Activity Calendar and led by Activities Staff. Attendance and participation were documented and maintained in the Activities Office, to be filed with the resident's medical record by the 5th day of the following month.  The facility has determined that all residents have the potential to be affected. The Activity Director reviewed activity attendance and participation records of residents for trends regarding activities. Follow-up interviews were conducted on 5 residents and completed to see if we are meeting their activity needs  The Activities Director provided education to Activities and Nursing Staff on their roles and responsibilities regarding activities. Attendance and participation in activities will be documented and	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

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F 0679  SS=E	Continued from page 63	F 0679	<p>maintained in the Activities Office during the current month and filed in each resident's medical record by the 5th day of the following month</p> <p>The Activities Director will review activity attendance and participation records monthly for trends regarding activities. Activities Staff will interview five residents weekly to determine activity preferences and to guide activity planning. For 3 months</p> <p>Findings will be discussed with the Resident Council and at the monthly Quality Assurance meeting until such a time consistent satisfaction is reported by the Resident Council.</p>	

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F 0679  SS=E	Continued from page 64  Based on a review of the facility policy, clinical record and staff interviews, it was determined that the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for eight of ten residents (Residents R5, R11, R26, R35, R41, R45, R52, and R55).  Findings included:  Review of the facility policy "Resident Rights" reviewed 10/20/24, indicated the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Self-Determination - "The resident has the right to, and the facility must promote and facilitate self-determination through support of resident choice, including but not limited to: The resident has a right to choose activities, schedules, health care and providers of health care services consistent with his or her interests, assessments and plan of care and other applicable provisions of this part."	F 0679		

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F 0679  SS=E	Continued from page 65  Review of the Resident Assessment Instrument 3.0 User's Manual, effective October 2023, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment  During Resident Group on 2/12/25, at 10:30 a.m. the attendees Resident R5, R26, and R52 reported there are fewer activities since activity director and one other activity staff member resigned. Resident Group members reported, "now there is only one part time activity aide in the facility, and she is doing the best she can."  Review of the clinical record indicated Resident R5 was originally admitted to the facility on 3/13/02.  Review of Resident R5's Minimum Data Set (MDS	F 0679		

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F 0679  SS=E	Continued from page 66  - a periodic assessment of care needs) dated 7/17/24, indicated diagnoses of anxiety, depression, and dementia, a BIMS of 15. Activity preferences are reading, music, animals, news, group activities, going outside, and participation in religious services.  Review of Resident R5's plan of care for leisure lifestyle choices and group activities initiated 11/28/17, and most recently revised 5/18/21, indicated the resident can make leisure lifestyle choices and attends daily group activities as an active participant daily. Resident does enjoy coloring, socializing, bingo, Resident Council President, arts/crafts, joking with staff and other residents she to receive a monthly activities calendar.  Review of Resident R5's clinical record for 1/25, revealed the facility failed to provide an ongoing program of activities to meet the resident's interests. Review of Resident R5's "Documentation Survey Report" indicated Resident R5 participated in group programs on four of thirty-one days, three on the	F 0679		

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F 0679  SS=E	<p>Continued from page 67</p> <p>evening shift (3 p.m. to 11 p.m.) and one on the night shift (11 p.m. 7 a.m.).</p> <p>During resident group interview on 2/11/25, at 10:30 a.m. Resident R5 stated, "the facility had a lot of group activities, not as many over the past months, we don't get the activities calendars anymore."</p> <p>Review of the clinical record indicated Resident R26 was originally admitted to the facility on 12/6/22.</p> <p>Review of Resident R26's MDS dated 11/8/24, indicated diagnoses of End Stage Renal Disease (kidney failure), COPD (lung disease), systemic lupus erythematosus (body's immune system attacks its own tissues), a BIMS of 15. Activity preferences are reading, music, animals, news, group activities, going outside, and participation in religious services.</p> <p>Review of Resident R26's plan of care for activities intervention for acknowledge and strive to maintain</p>	F 0679		

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F 0679  SS=E	Continued from page 68  positive compliance with treatment and care initiated 6/28/23.  Review of Resident R26's clinical record for 1/25, revealed the facility failed to provide an ongoing program of activities to meet the resident's interests. Review of Resident R26's "Documentation Survey Report" indicated Resident R26 had not participated in any group activity.  During resident group interview on 2/11/25, at 10:30 a.m. Resident R26 stated, "I agree with the group comments of there being few activities now."  Review of the clinical record indicated Resident R52 was originally admitted to the facility on 1/2/24.  Review of Resident R52's MDS dated 11/13/24, indicated diagnoses of coronary artery disease (heart disease), dementia, depression, a BIMS of 15. Activity preferences are reading, music, news, going outside, and participation in religious services.	F 0679		

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F 0679  SS=E	Continued from page 69  Review of Resident R52's plan of care for leisure lifestyle choices and group activities initiated 11/25/24, indicated the resident engages in daily activities of choice including reading his bible and sightseeing on the administrative floor with supervision/assistance.  Review of Resident R52's clinical record for 1/25, revealed the facility failed to provide an ongoing program of activities to meet the resident's interests. Review of Resident R52's "Documentation Survey Report" indicated Resident R52 had not participated in any group activity.  During resident council group interview on 2/11/25, at 10:30 a.m. Resident R52 stated, "since two of the three activity staff left, the one girl does the best she can when she is here."  Review of the clinical record indicated Resident R11 was admitted to the facility on 5/9/24.  Review of Resident R11's MDS dated 5/16/24,	F 0679		

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F 0679  SS=E	Continued from page 70  indicated diagnoses of Anxiety, depression, and hypertension (high blood pressure), a BIMS of 15. Activity preferences are reading, music, animals, news, group activities, and going outside.  Review of Resident R11's plan of care for activities intervention for encourage participation in enjoyable activities initiated 5/24/24.  Review of Resident R11's clinical record for 1/25, revealed the facility failed to provide an ongoing program of activities to meet the resident's interests. Review of Resident R11's "Documentation Survey Report" indicated Resident R11 participated in group programs on three of thirty-one days, on the evening shift (3 p.m. to 11 p.m.).  During an interview on 2/12/25, at 10:30 a.m. Resident R11 stated, "I like group activities and the games like cornhole they played here and crafts, they don't do many activities, crafts, or games now."  Review of the clinical record indicated Resident R35	F 0679		

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F 0679  SS=E	Continued from page 71  was admitted to the facility on 10/16/23.  Review of Resident R35's MDS dated 9/4/24, indicated diagnoses of Anxiety, depression, and coronary artery disease (heart disease), a BIMS of 15. Activity preferences are reading, music, animals, news, and going outside.  Review of Resident R35's plan of care for activities intervention do not leave unattended while smoking initiated 12/19/23.  Review of Resident R35's clinical record for 1/25, revealed the facility failed to provide an ongoing program of activities to meet the resident's interests. Review of Resident R35's "Documentation Survey Report" indicated Resident R35 participated in group programs on three of thirty-one days, three on the evening shift (3 p.m. to 11 p.m.).  During an interview on 2/12/25, at 10:45 a.m. Resident R35 stated, "I like going on the outings, they don't do that anymore, there's not much to do	F 0679		

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NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
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F 0679  SS=E	Continued from page 72  now.  Review of the clinical record indicated Resident R41 was admitted to the facility on 4/11/19.  Review of Resident R41's MDS dated 8/5/24, indicated diagnoses of stroke, depression, and dementia, a BIMS of 7. Activity preferences had not been prioritized.  Review of Resident R41's plan of care for leisure lifestyle choices and group activities initiated 4/21/21, and most recently revised 5/18/21, indicated the resident engages in daily independent activities of choice watching television, rosary, socializing with staff, wanting to sit outside when the weather is good and to receive a monthly activities calendar.  Review of Resident R41's clinical record for 1/25, revealed the facility failed to provide an ongoing program of activities to meet the resident's interests. Review of Resident R41's "Documentation Survey	F 0679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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F 0679  SS=E	Continued from page 73  Report" indicated Resident R41 had not participated in any group activity.  During an interview on 2/12/25, at 10:55 a.m. Resident R41 stated, "I don't get to do much with activities".  Review of the clinical record indicated Resident R45 was admitted to the facility on 1/13/25.  Review of Resident R45's MDS dated 1/17/25, indicated diagnoses of left shoulder fracture, depression, and dementia, a BIMS of 8. Activity preferences are reading, music, news, and going outside.  Review of Resident R45's plan of care does not address recreational activities.  Review of Resident R45's clinical record for 1/25, revealed the facility failed to provide an ongoing program of activities to meet the resident's interests. Review of Resident R41's "Documentation Survey	F 0679		

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F 0679  SS=E	Continued from page 74  Report" indicated Resident R45 had not participated in any group activity.  During an interview on 2/12/25, at 11:05 a.m. Resident R45 stated, "I haven't been here long and don't know many people".  Review of the clinical record indicated Resident R55 was admitted to the facility on 8/20/24.  Review of Resident R55's MDS dated 1/19/25, indicated diagnoses of schizoaffective disorder (mental illness affects thoughts, mood and behavior), diverticulitis of large intestine with perforation and abscess (inflammation of the colon), and hypertension (high blood pressure), a BIMS of 15. Activity preferences are reading, music, news, going outside, and participation in religious services.  Review of Resident R55's plan of care intervention for activities, offer activities for resident such as listening to music, watching sports etc... initiated 7/26/24.	F 0679		

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F 0679  SS=E	Continued from page 75  Review of Resident R55's clinical record for 1/25, revealed the facility failed to provide an ongoing program of activities to meet the resident's interests. Review of Resident R55's "Documentation Survey Report" indicated Resident R55 had not participated in any group activity.  During an interview on 2/12/25, at 11:15 a.m. Resident R55 stated, "I want to be able to go somewhere outside, you can't go anywhere or do anything outside of here."  During observation on the sixth floor on 2/12/25, at 5:00 p.m. it was observed fifteen of twenty resident rooms had activity calendars posted the heading is "January 2025" this was confirmed with the Director of Nursing (DON) on 2/12/25 at 5:00 p.m.  During an interview on 2/12/25, at 5:00 p.m. with the Nursing Home Administrator (NHA) and DON a request for the activity staff persons schedule, personnel file, interview and the activity calendar for	F 0679		

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F 0679  SS=E	<p>Continued from page 76</p> <p>the months of 10/24, 11/24,12/24 and 2/25 was made.</p> <p>During an interview on 2/13/25 at 1:30 p.m. the NHA confirmed the facility could not locate the personnel file of the employee, the requested activities calendars for 10/24, 11/24 and 12/24, or the activity employee schedule.</p> <p>During an interview on 2/14/25 at 10:30 a.m. the DON confirmed the facility was unable schedule the activity employee interview.</p> <p>During an interview on 2/13/25, at 12:00 p.m. the Nursing Home Administrator (NHA) confirmed the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for eight of ten residents (Residents R5, R11, R26, R35, R41, R45, R52, and R55).</p> <p>28 Pa. Code: 201. 18(b)(3) Management.</p>	F 0679		

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F 0679  SS=E	Continued from page 77  28 Pa. Code: 207.2(a) Administrators responsibility.	F 0679		
F 0680  SS=E	483.24(c)(2)(i)(ii)(A)-(D) Qualifications of Activity Professional  §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State.  This REQUIREMENT is not met as evidenced by:	F 0680	An activity director has been hired and is starting on March 17th, 2025.  This has the potential to have a negative effect on the residents.  The administrator will be educated by Clinical consultant on policy of hiring qualified Activity Director.  The administrator will audit to ensure month for 3 months there is a qualified activity professional on staff. Findings will be reported to the quality assurance and performance improvement committee.	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

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F 0680  SS=E	Continued from page 78  Based on staff interviews and review of facility provided documentation, it was determined the facility failed to provide a qualified professional to direct the activities program as required for two of 12 months (12/6/24 through 2/14/25).  Findings include:  Review of the Activities Director job description required Qualifications "The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional."  During an interview on 2/13/25, at 1:30 p.m. the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed the facility failed to provide a qualified professional to direct the activities program for two of 12 months (12/6/24 through 2/14/25).  28 Pa Code 201.18(b)(3) Management.	F 0680		

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F 0680  SS=E	Continued from page 79  28 Pa Code 201.18(e)(6) Management	F 0680		
F 0693  SS=D		F 0693		

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F 0693  SS=D	Continued from page 80  483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills  §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-  §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and  §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.  This REQUIREMENT is not met as evidenced by:	F 0693	Resident R20's tube feeding was taken down and hung with the correct date on the next administration.  The facility has determined that all residents receiving tube feeding have the potential to be affected if the tube feeding is not dated properly. All residents receiving tube feeding, bottle checked for proper dates and correct orders.  In-service education programs regarding the Tube Feeding Policy were conducted separately with licensed staff by the Director of Nursing Services (DON), or designee.  The Director of Nursing Services (DON), or designee, will conduct observations of dating tube feeding to take place three days per week for four weeks, then bi-weekly for one month, then monthly for one month.  Findings of this audit will be discussed with the Resident Council.	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

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F 0693  SS=D	Continued from page 81	F 0693	This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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F 0693  SS=D	Continued from page 82  Based on review of facility policy, manufacturer's information, clinical record review, observations, and staff interview, it was determined the facility failed to provide to provide appropriate care and services to residents receiving tube feedings for one of two residents reviewed (Residents R20).  Findings include:  The facility policy entitled "Care and Treatment of Feeding Tubes" (delivery of food or medication via tube surgically inserted into stomach) dated 10/20/24, indicated the facility must utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible.  Review of the manufacturer's information, "Glucerna 1.5 Cal" dated 9/7/24, indicated, "All medical foods, regardless of type of administration system, require careful handling because they can support microbial growth.  NOTE: Failure to follow the increases the potential	F 0693		

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F 0693  SS=D	Continued from page 83  for microbial contamination and may reduce Hang product for up to 48 hours after initial connection when clean technique and only one new set are used. Otherwise hang for no more than 24 hours  Review of the clinical record revealed that Resident R20 was originally admitted to the facility on 7/7/22, and readmitted on 10/17/24.  Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 2/2/25, included diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), dysphagia (difficulty swallowing), and hemiplegia (paralysis on one side of the body) following a stroke. Section K- Swallowing/Nutritional Status indicated the resident had a feeding tube while a resident.  Review of Resident R20's plan of care developed initiated 7/7/22, and updated 11/1/24, indicated Resident R20 required tube feedings related to	F 0693		

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F 0693  SS=D	Continued from page 84  dysphagia.  Review of a physician order dated 2/7/25, indicated that Resident R20 was to receive Glucerna 1.5 via peg-tube (a tube inserted through the abdominal wall that brings nutrition directly to the stomach) at a rate of 80 ml (milliliters) per hour, from 8:00 p.m. to 8:00 a.m.  During an observation on 2/13/25, at 11:38 a.m. Resident R20 was observed with his tube feeding attached. Observation of the tube feeding formula container did not show that it was dated when opened.  During an observation on 2/14/25, at 11:00 a.m. Resident R20's tube feeding formula container did not show that it was dated when opened.  During an interview on 2/14/25, at 11:02 a.m. Registered Nurse Employee E10 confirmed that the tube feeding container was still hanging, and that it was not possible to know what date it was opened.	F 0693		

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F 0693  SS=D	<p>Continued from page 85</p> <p>During an interview on 2/14/25, at 11:09 a.m. the Director of Nursing (DON) confirmed that when the tube feeding is stopped at 8:00 a.m. in the morning, the container should be removed as the formula should not be used after opened for 24 hours. The DON further confirmed that leaving the tube feeding container hanging after the stop time, without a date and time, provided the potential for the use of the tube feeding formula beyond the 24 hour limitation.</p> <p>During an interview on 2/14/25, at approximately 2:00 p.m. the Nursing Home Administrator and the the Director of Nursing confirmed the facility failed to provide to provide appropriate care and services to residents receiving tube feedings for one of two residents reviewed.</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p> <p>28 Pa. Code: 211.12(d)(1) Nursing services.</p>	F 0693		

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F 0693  SS=D	Continued from page 86  28 Pa. Code: 211.10(c) Resident care policies.	F 0693		
F 0698  SS=D		F 0698		

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F 0698  SS=D	Continued from page 87  483.25(l) Dialysis  §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.  This REQUIREMENT is not met as evidenced by:	F 0698	Dialysis book of #R18 reviewed by the Director of Nursing Services, or designee, with the attending physician and dialysis provider. We are unable to correct uncharted documentation from the dialysis center.  The facility has determined that residents who receive dialysis have the potential to be affected by poor communication between the nursing facility and the dialysis center.  In-service education was conducted by the Director of Nursing Services or designee on dialysis communication to the licensed staff. The dialysis center was informed of the proper procedure as it relates to the nursing facility's documentation and communication.  The Director of Nursing Services or designees will review the dialysis communication books of each resident receiving dialysis weekly for four weeks, then bi-weekly for one month to ensure the dialysis center's	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
STATE LICENSE NUMBER: <b>231602</b>				
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F 0698  SS=D	Continued from page 88	F 0698	documentation is complete. Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
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F 0698  SS=D	Continued from page 89  Based on review of facility policy and clinical records, and staff interview, it was determined that facility staff failed to maintain ongoing communication with the hemodialysis (a machine filters wastes, salts and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately) center for one of two residents reviewed (Resident R18).  Findings include:  A review of the facility policy "Hemodialysis" reviewed 10/20/24, indicated residents ordered dialysis will have ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. The licensed nurse will communicate via written format with a dialysis communication form.  A review of the clinical record indicated Resident R18 was re-admitted to the facility on 5/9/24, with diagnoses that included end-stage renal disease (ESRD - the kidneys permanently fail to work) and	F 0698		

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F 0698  SS=D	Continued from page 90  low blood pressure. A review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 2/2/25, indicated the diagnoses remain current.  A review of a physician's order summary dated 1/1/25 through 2/28/25, indicated Resident R18 was to receive dialysis three days a week on Tuesday, Thursday, and Saturday. A review of the nurse progress notes indicated Resident R18 receives dialysis three times a week.  A review of Resident R18's "Dialysis Hand Off Communication Report" forms from 1/14/25 through 2/13/25, revealed 9 communication forms out of 9 scheduled treatments were observed. The section to be completed by dialysis and returned with the resident were left blank on 1/14, 1/16, 1/21, 1/25, 1/28, 1/30, 2/6, 2/8, and 2/13/25.  During an interview on 2/14/25, at 1:00 p.m. the Director of Nursing confirmed the above findings and the facility failed to ensure the dialysis	F 0698		

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F 0698  SS=D	Continued from page 91  communication form was completed between the facility and dialysis center for Resident R18.  28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.	F 0698		
F 0699  SS=D		F 0699		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
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F 0699  SS=D	Continued from page 92  483.25(m) Trauma Informed Care  §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.  This REQUIREMENT is not met as evidenced by:	F 0699	Resident #58 continues to reside in the facility, Password for visitors has been added to her profile per resident request. Residents #20, 30 & 58 will have Trauma Informed Assessment and Care plan with interventions.  Residents who have experienced Trauma in their lives have the potential to be affected. Social Services and Nursing will assess residents with Trauma Informed Assessment and develop care plans with interventions for the residents that require them.  Facility administrator or designee provided education to Social Services Director and Licensed Nursing Staff regarding the need to assess residents for Trauma and develop care plans with interventions.  Social Services will conduct weekly audit on all new admissions for 4 weeks, then monthly for 2 months to ensure that a Trauma Informed Care	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

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NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
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F 0699  SS=D	Continued from page 93	F 0699	Assessment has been completed and if necessary, care plan with interventions has been developed.  Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee.	

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F 0699  SS=D	Continued from page 94  Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to provide culturally competent, trauma care in accordance with professional standards of practice, accounting for the resident's past experiences and preferences in order to eliminate and/or mitigate triggers that may cause re-traumatization of the resident for three of eight residents (Resident R58, R20, and R30).  Findings include:  Review of the facility policy, "Trauma Informed Care" dated 10/20/24, indicated the facility will provide care and services which are delivered using approaches which are culturally-competent, account for experienced and preferences, ad address the needs of trauma survivors by minimizing triggers and/or retraumatization. The policy indicated trauma results from an event, series of events, or set of circumstances that is experienced by an individual ' s physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual.	F 0699		

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F 0699  SS=D	Continued from page 95  Included in the list of common sources was violent crime.  Review of the clinical record revealed that Resident R58 was admitted to the facility on 9/20/23.  Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 1/23/25, included diagnoses of unspecified multiple injuries, fractures of both femurs (upper leg bones), insomnia, and depression.  Review of a progress note dated 1/14/25, indicated Resident R58 has a history of GSW (gunshot wound) to legs and left hand and was admitted to [hospital] as level 1 trauma and had emergency surgery for BL (bilateral, both sides of the body) femur fractures and had IM nail (a metal rod forced into the cavity of a bone). Has significant pain legs and difficulty ambulating.  Review of Resident R58's evaluations failed to reveal an assessment for trauma-informed care or	F 0699		

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F 0699  SS=D	Continued from page 96  possible post-traumatic stress disorder. (PTSD, mental health condition triggered by experiencing or witnessing a terrifying event).  Review of a progress note dated 1/16/25, indicated Resident R58 has moderate depression.  Review of Resident R58's Social History Assessment completed on 1/16/25, at 1:28 p.m. indicated Resident R58 experienced anxiety, agitation, and depression.  Review of a progress note dated 2/12/25, at 10:53 a.m. Resident R58 reported increased anxiety.  Review of Resident R58's plan of care developed 1/14/25, failed to include goals and interventions related to trauma-informed care.  During an interview on 2/12/25, at 1:25 p.m. Resident R58 stated she had five gunshot wounds, and the perpetrator has not been apprehended. Resident R58 stated she had set up a code word on	F 0699		

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F 0699  SS=D	Continued from page 97  admission, but she is worried that the facility does not stop visitors when they enter the building before being allowed on the elevator. Additionally, Resident R58 requested that her name not be placed outside of her door, identifying her room. Observation at this time revealed Resident R58's name placed outside of her door.  Review of the clinical record revealed that Resident R20 was originally admitted to the facility on 7/7/22, and readmitted on 10/17/24.  Review of the MDS dated 2/2/25, included diagnoses of anxiety, depression, and PTSD.  Review of Resident R20's plan of care developed initiated 7/7/22, and updated 11/1/24, failed to include goals and interventions related to PTSD.  Review of Resident R20's evaluations failed to reveal an assessment for trauma-informed care or PTSD.	F 0699		

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F 0699  SS=D	Continued from page 98  Review of the clinical record revealed that Resident R30 was admitted to the facility on 3/28/23.  Review of the MDS dated 2/2/25, included diagnoses of anxiety, depression, and PTSD.  Review of Resident R30's plan of care developed initiated 12/3/23, and updated 8/261/24, failed to include goals and interventions related to PTSD.  Review of Resident R30's evaluations failed to reveal an assessment for trauma-informed care or PTSD.  During an interview on 2/14/25, at approximately 11:00 a.m. the Director of Nursing that the facility failed to provide culturally competent, trauma care in accordance with professional standards of practice, accounting for the resident's past experiences and preferences in order to eliminate and/or mitigate triggers that may cause re-traumatization of the resident for three of eight residents.	F 0699		

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F 0699  SS=D	Continued from page 99  28 Pa. Code 211.10 (a) Resident care policies.  28 Pa. Code 211.12(d)(3)(5) Nursing services.	F 0699		
F 0730  SS=D		F 0730		

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F 0730  SS=D	Continued from page 100  483.35(d)(7) Nurse Aide Peform Review-12 hr/yr In-Service  §483.35(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 §483.95(g).  This REQUIREMENT is not met as evidenced by:	F 0730	A performance review was conducted with E3 by the Director of Nursing.  Residents of the facility have the potential to be affected by this practice. The Human Resources Director will audit the Nurse Aide Employee files to ensure an annual performance review has been completed with Nurse Aides. Any Nurse Aide without an annual performance review will have one.  A facility procedure regarding the annual performance review process was put into place 2/21/25. Director of Nursing and Human Resources Director received education from the Administrator, regarding the process of providing Nurse Aides Annual Performance Reviews.  The Human Resources Director will review the schedule for each nurse's aides file that is due that month and corresponding documentation for (3) months to ensure compliance.	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

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F 0730  SS=D	Continued from page 101	F 0730	Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
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F 0730  SS=D	Continued from page 102  Based on review of facility policy, personnel records, and staff interview it was determined that the facility failed to complete annual performance evaluations for one out of four nurse aides (NA Employee E3).  Findings include:  Review of nurse aide performance evaluations completed by the facility failed to include a performance evaluation for Nurse Aide Employee E3, with a hire date of 10/11/04.  During an interview on 2/14/25, at approximately 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to complete annual performance evaluations for one of four nurse aides as required.  28 Pa Code: 201.20 (a)(b)(c)(d) Staff development.	F 0730		

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F 0730  SS=D	Continued from page 103  28 Pa Code: 201.14 (a) Responsibility of licensee.	F 0730		
F 0756  SS=D	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On  §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  §483.45(c)(2) This review must include a review of the resident's medical chart.  §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to	F 0756	Residents R 5 and R 56 medication regime review was completed by clinical pharmacist. Like residents have the potential to be affected.  A house audit was completed by a clinical pharmacist to ensure current residents had a completed medication regime review.  The Director of nursing and clinical pharmacist were educated on medication regime reviews by administrator of designee.  The Director of nursing will audit the clinical pharmacist medication regime reviews monthly for compliance. Findings will be reported to quality assurance meetings.	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
STATE LICENSE NUMBER: <b>231602</b>				
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F 0756  SS=D	Continued from page 104  address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.  §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.  This REQUIREMENT is not met as evidenced by:	F 0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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F 0756  SS=D	Continued from page 105  Based on facility policy, clinical record review and staff interview, it was determined that the facility failed to ensure the pharmacy completed a Medication Regime Review (MRR) at least monthly for two of five residents (Resident R5 and R56).  Findings:  Review of facility policy "Medication Regimen Review" reviewed 10/20/24, indicated the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist. The Medication Regimen Review (MRR) is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medications.  Review of the clinical record revealed Resident R5 was admitted to the facility on 3/13/02, with diagnoses that included dementia (group of symptoms affecting memory, thinking and social abilities), depression, and diabetes.	F 0756		

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F 0756  SS=D	Continued from page 106  Review of Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 11/6/24, indicated the diagnoses remain current.  Review of the care plan dated 2/9/20, indicated to consult with pharmacy, and MD to gradually reduce dosages if clinically appropriate to do so.  Review of Resident R5 clinical record failed to indicate a MRR was completed for February 2024, April 2024, May 2024, June 2024, July 2024, September 2024, October 2024, and November 2024.  Review of the clinical record indicated Resident R56 was admitted to the facility on 5/30/24, with diagnoses that included high blood pressure, diabetes, and dementia.  Review of MDS dated 12/27/24, indicated the diagnoses remain current.	F 0756		

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F 0756  SS=D	Continued from page 107  Review of the care plan dated 5/31/24, indicated to consult with pharmacy, and MD to gradually reduce dosages if clinically appropriate to do so.  Review of Resident R56 clinical record failed to indicate a MRR was completed for September 2024, October 2024, November 2024, and December 2024.  During an interview on 2/14/25, at 2:00 p.m. the Director of Nursing confirmed the facility failed to complete monthly pharmacy MRR's.	F 0756		
F 0842  SS=D		F 0842		

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F 0842  SS=D	Continued from page 108  483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information  §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.  §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized  §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 0842	R 59 and R 61 have been discharged so we cannot update the discharge summary and disposition of medication.  Like residents can be affected.  Medical records and licensed staff have been educated by the director of nursing or designee on discharge medical records to include discharge summary and disposition of medications.  Medical records will audit 5 discharge records a week for 4 weeks to ensure that discharge summaries and disposition of medications are completed.  Findings will be reported to the quality assurance and process improvement committee meetings.	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

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F 0842  SS=D	Continued from page 109  (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.  §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.  §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.  §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842		

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F 0842  SS=D	Continued from page 110  This REQUIREMENT is not met as evidenced by:	F 0842		

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F 0842  SS=D	Continued from page 111  Based on review of facility policies and clinical records and staff interview, it was determined that the facility failed to make certain that medical records on each resident are complete and accurately documented for two of four residents (Residents R59 and R61)  A review of the facility policy "Documentation in the Clinical Record" dated 10/20/24, indicated the resident's medical record shall be complete, accurate, and timely.  During an interview on 2/13/25, at 1:00 p.m. the Director of Nursing revealed that clinical records shall be completed within 30 days of a resident discharge from the facility.  A review of the clinical record on 2/13/25, indicated that Resident R59 was admitted to the facility on 1/26/24 and ceased to breathe on 12/2/24.  A review of the "Interdisciplinary Discharge Summary" and "Disposition of Medications" forms	F 0842		

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F 0842  SS=D	Continued from page 112  dated 12/2/24, were not completed.  A review of the clinical record on 2/13/25, indicated that Resident R61 was admitted to the facility 10/14/24, and discharged on 11/19/24.  A review of the "Interdisciplinary Discharge Summary" and "Disposition of Medications" forms dated 11/19/24, were not completed.  During an interview on 2/13/25 at 1:00 p.m., The Director of Nursing (DON) confirmed the above findings, and the facility failed to make certain that medical records on each resident are complete and accurately documented for Residents R59 and R61.  28 Pa. Code: 211.5(f)(g)(h) Clinical records.	F 0842		
F 0868  SS=E		F 0868		

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F 0868  SS=E	Continued from page 113  483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) QAA Committee  §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist.  §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.  §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member	F 0868	Facility determined that not having quarterly quality assurance meetings could negatively affect the residents.  Administrator and Director of nursing will be educated and educate all managers on the importance of regularly scheduled quality assurance meetings by regional clinical nurse.  Administrator or designee will audit compliance with the quality assurance meetings. Findings will be reported at the quality assurance meetings.	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

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F 0868  SS=E	Continued from page 114  of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.  This REQUIREMENT is not met as evidenced by:	F 0868		

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F 0868  SS=E	Continued from page 115  Based on facility policy review, review of Quality Assurance attendance records, and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for three of four quarterly meetings (January 2024 through December 2024).  Findings Include:  The facility "Quality Assurance and Performance Improvement (QAPI) Program" policy dated 10/20/24, indicated that the facility shall develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. The QAA committee shall meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program.  A review of the Quality assurance and performance	F 0868		

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F 0868  SS=E	Continued from page 116  improvement sign in sheets and attendance records indicated the facility had a first quarter meeting on 2/22/24. The facility failed to failed to provide evidence that the facility conducted a second third and fourth quarter meeting for 2024.  During an interview on 2/14/25, at 10:20 a.m. the Director of Nursing (DON) confirmed that the facility failed to conduct QAA meetings at least quarterly with all the required committee members for three of four quarterly meetings (January 2024 through December 2024), as required.  28 Pa Code: 201.18(e)(1)(2)(3)(4) Management.	F 0868		
F 0940  SS=E		F 0940		

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F 0940  SS=E	Continued from page 117  483.95 Training Requirements  §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.71. Training topics must include but are not limited to-  This REQUIREMENT is not met as evidenced by:	F 0940	No residents were affected by this deficiency.  All residents have the potential to be affected by this deficiency.  VP of Clinical Services, Administrator and Director of Nursing developed a facility Training Plan to include:  Effective communication for direct care staff.  Resident rights and facility responsibilities for caring of residents.  Elements and goals of the facility's QAPI program.  Written standards, policies, and procedures for the facility's infection prevention and control program.  Written standards, policies, and procedures for the facility's compliance and ethics program.	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

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STATE LICENSE NUMBER: <b>231602</b>				
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F 0940  SS=E	Continued from page 118	F 0940	<p>Behavioral health.</p> <p>Dementia management and care of the cognitively impaired.</p> <p>Abuse, neglect, and exploitation prevention.</p> <p>Safety and emergency procedures.</p> <p>All staff will receive education in these areas, provided by the Administrator and Director of nursing or designee. Completed training will be signed and dated by staff after receiving the training. Moving forward staff will receive this training upon hire (during orientation) and annually.</p> <p>Human Resources Director will complete a weekly audit for 4 weeks on all new hires to ensure they have received the required trainings in the training plan and will complete a monthly audit that all staff have completed the assigned monthly</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
STATE LICENSE NUMBER: <b>231602</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0940  SS=E	Continued from page 119	F 0940	<p>trainings to ensure continued annual training.</p> <p>Audit results will be reviewed by the Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0940  SS=E	Continued from page 120  Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to implement and maintain an effective training program for four of four nurse aides (Employee E1, E3, E4, and E5).  Findings include:  Review of the facility policy, "Training Requirements" most recently reviewed 10/20/24, indicated the facility will develop, implement, and maintain an effective training program for all new and existing staff.  Review of facility provided documents and training records revealed the following:  Nurse Aide (NA) Employee E1 had a hire date of 10/9/22. The facility provided education filed failed to have any dates or times provided on any documents within the file.  NA Employee E3 had a hire date of 10/11/04. The	F 0940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
STATE LICENSE NUMBER: <b>231602</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0940  SS=E	Continued from page 121  facility was unable to provide an education file or any other documentation that NA Employee E3 had completed any education from 10/11/23, through 10/11/24.  NA Employee E4 had a hire date of 10/11/05. The facility provided education filed revealed a "12-hour in-service packet," but no dates were present confirmed that the education occurred between 10/11/23, through 10/11/24.  NA Employee E5 had a hire date of 11/12/13. The facility provided education filed revealed a "12-hour in-service packet," but no dates were present confirmed that the education occurred between 11/12/23, through 11/12/24.  During an interview on 2/14/25, at approximately 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on infection prevention and control program for six of nine staff members.	F 0940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
STATE LICENSE NUMBER: <b>231602</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0940  SS=E	Continued from page 122  28 Pa Code: 201.14 (a) Responsibility of licensee.  28 Pa Code: 201.18 (b)(1) Management.  28 Pa Code: 201.20 (a)(c) Staff development.	F 0940		
F 0941  SS=E		F 0941		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>
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F 0941  SS=E	Continued from page 123  483.95(a) Communication Training  §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff.  This REQUIREMENT is not met as evidenced by:	F 0941	No residents were affected by this deficiency.  Residents have the potential to be affected by this deficiency.  VP of Clinical Services, Administrator and Director of Nursing developed a facility Training Plan to include:  Effective communication for direct care staff.  Resident rights and facility responsibilities for caring of residents.  Elements and goals of the facility's QAPI program.  Written standards, policies, and procedures for the facility's infection prevention and control program.  Written standards, policies, and procedures for the facility's compliance and ethics program.	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0941  SS=E	Continued from page 124	F 0941	<p>Behavioral health.</p> <p>Dementia management and care of the cognitively impaired.</p> <p>Abuse, neglect, and exploitation prevention.</p> <p>Safety and emergency procedures.</p> <p>All staff will receive education in these areas, provided by the Administrator and Director of nursing or designee. Completed training will be signed and dated by staff after receiving the training. Moving forward staff will receive this training upon hire (during orientation) and annually.</p> <p>Human Resources Director will complete a weekly audit for 4 weeks on all new hires to ensure they have received the required trainings in the training plan and will complete a monthly audit that all staff have completed the assigned monthly</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0941  SS=E	Continued from page 125	F 0941	<p>trainings to ensure continued annual training.</p> <p>Audit results will be reviewed by the Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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STATE LICENSE NUMBER: <b>231602</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0941  SS=E	Continued from page 126  Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on Effective Communication for five of nine staff members (Employee E1, E3, E4, E7, and E8).  Findings include:  Review of the facility policy, "Training Requirements" most recently reviewed 10/20/24, indicated the facility will develop, implement, and maintain an effective training program for all new and existing staff. Training content includes, at a minimum: a. Effective communication for direct care staff. b. Resident rights and facility responsibility for caring of residents. c. Elements and goals of the facility's Quality Assurance and Performance Improvement program. d. Written standards, policies, and procedures for the facility's infection prevention and control program. e. Written standards, policies, and procedures for	F 0941		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
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F 0941  SS=E	<p>Continued from page 127</p> <p>the facility's compliance and ethics program.</p> <p>f. Behavioral health.</p> <p>g. Dementia management and care of the cognitively impaired.</p> <p>h. Abuse, neglect, and exploitation prevention.</p> <p>i. Safety and emergency procedures.</p> <p>Review of facility provided documents and training records revealed the following staff members did not have documented training on the effective communication.</p> <p>Nurse Aide (NA) Employee E1 had a hire date of 10/9/22, failed to have effective communication in-service education between 10/9/23, and 10/9/24.</p> <p>NA Employee E3 had a hire date of 10/11/04, failed to have effective communication in-service education between 10/11/23, and 10/11/24.</p> <p>NA Employee E4 had a hire date of 10/11/05, failed to have effective communication in-service education between 10/11/23, and 10/11/24.</p>	F 0941		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
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F 0941  SS=E	Continued from page 128  Dietary Employee E7 had a hire date of 12/27/15, failed to have effective communication in-service education between 12/27/23, and 12/27/24.  Licensed Practical Nurse Employee E8 had a hire date of 12/27/15, failed to have effective communication in-service education between 12/27/23, and 12/27/24.  During an interview on 2/14/25, at approximately 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on effective communication for five of nine staff members.  28 Pa Code: 201.14 (a) Responsibility of licensee.  28 Pa Code: 201.18 (b)(1) Management.  28 Pa Code: 201.20 (a)(c) Staff development.	F 0941		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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F 0942  SS=E		F 0942		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
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F 0942  SS=E	Continued from page 130  483.95(b) Resident Rights Training  §483.95(b) Resident's rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively.  This REQUIREMENT is not met as evidenced by:	F 0942	No residents were affected by this deficiency.  All residents have the potential to be affected by this deficiency.  VP of Clinical Services, Administrator and Director of Nursing developed a facility Training Plan to include:  Effective communication for direct care staff.  Resident rights and facility responsibilities for caring of residents.  Elements and goals of the facility's QAPI program.  Written standards, policies, and procedures for the facility's infection prevention and control program.  Written standards, policies, and procedures for the facility's compliance and ethics program.	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
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F 0942  SS=E	Continued from page 131	F 0942	<p>Behavioral health.</p> <p>Dementia management and care of the cognitively impaired.</p> <p>Abuse, neglect, and exploitation prevention.</p> <p>Safety and emergency procedures.</p> <p>All staff will receive education in these areas, provided by the Administrator and Director of nursing. Completed training will be signed and dated by staff after receiving the training. Moving forward staff will receive this training upon hire (during orientation) and annually.</p> <p>Human Resources Director will complete a weekly audit for 4 weeks on all new hires to ensure they have received the required trainings in the training plan and will complete a monthly audit that all staff have completed the assigned monthly</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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F 0942  SS=E	Continued from page 132	F 0942	<p>trainings to ensure continued annual training.</p> <p>Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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F 0942  SS=E	Continued from page 133  Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on Resident Rights for six of nine staff members (Employee E1, E3, E4, E7, E8, and E9).  Findings include:  Review of the facility policy, "Training Requirements" most recently reviewed 10/20/24, indicated the facility will develop, implement, and maintain an effective training program for all new and existing staff. Training content includes, at a minimum: a. Effective communication for direct care staff. b. Resident rights and facility responsibility for caring of residents. c. Elements and goals of the facility's Quality Assurance and Performance Improvement program. d. Written standards, policies, and procedures for the facility's infection prevention and control program. e. Written standards, policies, and procedures for	F 0942		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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F 0942  SS=E	Continued from page 134  the facility's compliance and ethics program. f. Behavioral health. g. Dementia management and care of the cognitively impaired. h. Abuse, neglect, and exploitation prevention. i. Safety and emergency procedures.  Review of facility provided documents and training records revealed the following staff members did not have documented training on the resident rights.  Nurse Aide (NA) Employee E1 had a hire date of 10/9/22, failed to have resident rights in-service education between 10/9/23, and 10/9/24.  NA Employee E3 had a hire date of 10/11/04, failed to have resident rights in-service education between 10/11/23, and 10/11/24.  NA Employee E4 had a hire date of 10/11/05, failed to have resident rights in-service education between 10/11/23, and 10/11/24.	F 0942		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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STATE LICENSE NUMBER: <b>231602</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0942  SS=E	Continued from page 135  Dietary Employee E7 had a hire date of 12/27/15, failed to have resident rights in-service education between 12/27/23, and 12/27/24.  Licensed Practical Nurse Employee E8 had a hire date of 12/27/15, failed to have resident rights in-service education between 12/27/23, and 12/27/24.  Maintenance Director Employee E9 had a hire date of 8/21/18, failed to have resident rights in-service education between 8/21/23, and 8/21/24.  During an interview on 2/14/25, at approximately 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on resident rights for six of nine staff members.  28 Pa Code: 201.14 (a) Responsibility of licensee.  28 Pa Code: 201.18 (b)(1) Management.  28 Pa Code: 201.20 (a)(c) Staff development.	F 0942		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0943  SS=E		F 0943		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
STATE LICENSE NUMBER: <b>231602</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0943  SS=E	Continued from page 137  483.95(c)(1)-(3) Abuse, Neglect, and Exploitation Training  §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-  §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.  §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property  §483.95(c)(3) Dementia management and resident abuse prevention.  This REQUIREMENT is not met as evidenced by:	F 0943	No residents were affected by this deficiency.  All residents have the potential to be affected by this deficiency.  VP of Clinical Services, Administrator and Director of Nursing developed a facility Training Plan to include:  Effective communication for direct care staff.  Resident rights and facility responsibilities for caring of residents.  Elements and goals of the facility's QAPI program.  Written standards, policies, and procedures for the facility's infection prevention and control program.  Written standards, policies, and procedures for the facility's compliance and ethics program.	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0943  SS=E	Continued from page 138	F 0943	<p>Behavioral health.</p> <p>Dementia management and care of the cognitively impaired.</p> <p>Abuse, neglect, and exploitation prevention.</p> <p>Safety and emergency procedures.</p> <p>All staff will receive education in these areas, provided by the Administrator and Director of nursing or designee. Completed training will be signed and dated by staff after receiving the training. Moving forward staff will receive this training upon hire (during orientation) and annually.</p> <p>Human Resources Director will complete a weekly audit for 4 weeks on all new hires to ensure they have received the required trainings in the training plan and will complete a monthly audit that all staff have completed the assigned monthly</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
STATE LICENSE NUMBER: <b>231602</b>				
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F 0943  SS=E	Continued from page 139	F 0943	<p>trainings to ensure continued annual training.</p> <p>Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0943  SS=E	Continued from page 140  Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on Abuse and Neglect Prevention for six of nine staff members (Employee E1, E3, E4, E7, E8, and E9).  Findings include:  Review of the facility policy, "Training Requirements" most recently reviewed 10/20/24, indicated the facility will develop, implement, and maintain an effective training program for all new and existing staff. Training content includes, at a minimum: a. Effective communication for direct care staff. b. Resident rights and facility responsibility for caring of residents. c. Elements and goals of the facility's Quality Assurance and Performance Improvement program. d. Written standards, policies, and procedures for the facility's infection prevention and control program.	F 0943		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0943  SS=E	Continued from page 141  e. Written standards, policies, and procedures for the facility's compliance and ethics program. f. Behavioral health. g. Dementia management and care of the cognitively impaired. h. Abuse, neglect, and exploitation prevention. i. Safety and emergency procedures.  Review of facility provided documents and training records revealed the following staff members did not have documented training on the abuse and neglect prevention.  Nurse Aide (NA) Employee E1 had a hire date of 10/9/22, failed to have abuse and neglect prevention in-service education between 10/9/23, and 10/9/24.  NA Employee E3 had a hire date of 10/11/04, failed to have abuse and neglect prevention in-service education between 10/11/23, and 10/11/24.  NA Employee E4 had a hire date of 10/11/05,	F 0943		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0943  SS=E	Continued from page 142  failed to have abuse and neglect prevention in-service education between 10/11/23, and 10/11/24.  Dietary Employee E7 had a hire date of 12/27/15, failed to have abuse and neglect prevention in-service education between 12/27/23, and 12/27/24.  Licensed Practical Nurse Employee E8 had a hire date of 12/27/15, failed to have abuse and neglect prevention in-service education between 12/27/23, and 12/27/24.  Maintenance Director Employee E9 had a hire date of 8/21/18, failed to have abuse and neglect prevention in-service education between 8/21/23, and 8/21/24.  During an interview on 2/14/25, at approximately 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on abuse and neglect prevention for six of nine staff	F 0943		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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STATE LICENSE NUMBER: <b>231602</b>				
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F 0943  SS=E	Continued from page 143  members.  28 Pa Code: 201.14 (a) Responsibility of licensee.  28 Pa Code: 201.18 (b)(1) Management.  28 Pa Code: 201.20 (a)(c) Staff development.	F 0943		
F 0944  SS=E		F 0944		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>
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F 0944  SS=E	Continued from page 144  483.95(d) QAPI Training  §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75.  This REQUIREMENT is not met as evidenced by:	F 0944	No residents were affected by this deficiency.  All residents have the potential to be affected by this deficiency.  VP of Clinical Services, Administrator and Director of Nursing developed a facility Training Plan to include:  Effective communication for direct care staff.  Resident rights and facility responsibilities for caring of residents.  Elements and goals of the facility's QAPI program.  Written standards, policies, and procedures for the facility's infection prevention and control program.  Written standards, policies, and procedures for the facility's compliance and ethics program.	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
STATE LICENSE NUMBER: <b>231602</b>				
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F 0944  SS=E	Continued from page 145	F 0944	<p>Behavioral health.</p> <p>Dementia management and care of the cognitively impaired.</p> <p>Abuse, neglect, and exploitation prevention.</p> <p>Safety and emergency procedures.</p> <p>All staff will receive education in these areas, provided by the Administrator and Director of nursing or designee. Completed training will be signed and dated by staff after receiving the training. Moving forward staff will receive this training upon hire (during orientation) and annually.</p> <p>Human Resources Director will complete a weekly audit for 4 weeks on all new hires to ensure they have received the required trainings in the training plan and will complete a monthly audit that all staff have completed the assigned monthly</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
STATE LICENSE NUMBER: <b>231602</b>				
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F 0944  SS=E	Continued from page 146	F 0944	<p>trainings to ensure continued annual training.</p> <p>Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0944  SS=E	Continued from page 147  Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on the Quality Assurance and Performance Improvement (QAPI) program for six of nine staff members (Employee E1, E3, E4, E7, E8, and E9).  Findings include:  Review of the facility policy, "Training Requirements" most recently reviewed 10/20/24, indicated the facility will develop, implement, and maintain an effective training program for all new and existing staff. Training content includes, at a minimum: a. Effective communication for direct care staff. b. Resident rights and facility responsibility for caring of residents. c. Elements and goals of the facility's Quality Assurance and Performance Improvement program. d. Written standards, policies, and procedures for the facility's infection prevention and control program.	F 0944		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0944  SS=E	Continued from page 148  e. Written standards, policies, and procedures for the facility's compliance and ethics program. f. Behavioral health. g. Dementia management and care of the cognitively impaired. h. Abuse, neglect, and exploitation prevention. i. Safety and emergency procedures.  Review of facility provided documents and training records revealed the following staff members did not have documented training on the QAPI program.  Nurse Aide (NA) Employee E1 had a hire date of 10/9/22, failed to have the QAPI program in-service education between 10/9/23, and 10/9/24.  NA Employee E3 had a hire date of 10/11/04, failed to have the QAPI program in-service education between 10/11/23, and 10/11/24.  NA Employee E4 had a hire date of 10/11/05, failed to have the QAPI program in-service education between 10/11/23, and 10/11/24.	F 0944		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0944  SS=E	Continued from page 149  Dietary Employee E7 had a hire date of 12/27/15, failed to have the QAPI program in-service education between 12/27/23, and 12/27/24.  Licensed Practical Nurse Employee E8 had a hire date of 12/27/15, failed to have the QAPI program in-service education between 12/27/23, and 12/27/24.  Maintenance Director Employee E9 had a hire date of 8/21/18, failed to have the QAPI program in-service education between 8/21/23, and 8/21/24.  During an interview on 2/14/25, at approximately 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on the QAPI program for six of nine staff members.  28 Pa Code: 201.14 (a) Responsibility of licensee.  28 Pa Code: 201.18 (b)(1) Management.  28 Pa Code: 201.20 (a)(c) Staff development.	F 0944		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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F 0945  SS=E		F 0945		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0945  SS=E	Continued from page 151  483.95(e) Infection Control Training  §483.95(e) Infection control. A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at §483.80(a)(2).  This REQUIREMENT is not met as evidenced by:	F 0945	No residents were affected by this deficiency.  All residents have the potential to be affected by this deficiency.  VP of Clinical Services, Administrator and Director of Nursing developed a facility Training Plan to include:  Effective communication for direct care staff.  Resident rights and facility responsibilities for caring of residents.  Elements and goals of the facility's QAPI program.  Written standards, policies, and procedures for the facility's infection prevention and control program.  Written standards, policies, and procedures for the facility's compliance and ethics program.	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
STATE LICENSE NUMBER: <b>231602</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0945  SS=E	Continued from page 152	F 0945	<p>Behavioral health.</p> <p>Dementia management and care of the cognitively impaired.</p> <p>Abuse, neglect, and exploitation prevention.</p> <p>Safety and emergency procedures.</p> <p>All staff will receive education in these areas, provided by the Administrator and Director of nursing or designee. Completed training will be signed and dated by staff after receiving the training. Moving forward staff will receive this training upon hire (during orientation) and annually.</p> <p>Human Resources Director will complete a weekly audit for 4 weeks on all new hires to ensure they have received the required trainings in the training plan and will complete a monthly audit that all staff have completed the assigned monthly</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0945  SS=E	Continued from page 153	F 0945	<p>trainings to ensure continued annual training.</p> <p>Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0945  SS=E	Continued from page 154  Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on the Infection Prevention and Control program for six of nine staff members (Employee E1, E3, E4, E7, E8, and E9).  Findings include:  Review of the facility policy, "Training Requirements" most recently reviewed 10/20/24, indicated the facility will develop, implement, and maintain an effective training program for all new and existing staff. Training content includes, at a minimum: a. Effective communication for direct care staff. b. Resident rights and facility responsibility for caring of residents. c. Elements and goals of the facility's Quality Assurance and Performance Improvement program. d. Written standards, policies, and procedures for the facility's infection prevention and control program.	F 0945		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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F 0945  SS=E	Continued from page 155  e. Written standards, policies, and procedures for the facility's compliance and ethics program. f. Behavioral health. g. Dementia management and care of the cognitively impaired. h. Abuse, neglect, and exploitation prevention. i. Safety and emergency procedures.  Review of facility provided documents and training records revealed the following staff members did not have documented training on the infection prevention and control program.  Nurse Aide (NA) Employee E1 had a hire date of 10/9/22, failed to have infection prevention and control program in-service education between 10/9/23, and 10/9/24.  NA Employee E3 had a hire date of 10/11/04, failed to have infection prevention and control program in-service education between 10/11/23, and 10/11/24.	F 0945		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0945  SS=E	Continued from page 156  NA Employee E4 had a hire date of 10/11/05, failed to have infection prevention and control program in-service education between 10/11/23, and 10/11/24.  Dietary Employee E7 had a hire date of 12/27/15, failed to have infection prevention and control program in-service education between 12/27/23, and 12/27/24.  Licensed Practical Nurse Employee E8 had a hire date of 12/27/15, failed to have infection prevention and control program in-service education between 12/27/23, and 12/27/24.  Maintenance Director Employee E9 had a hire date of 8/21/18, failed to have infection prevention and control program in-service education between 8/21/23, and 8/21/24.  During an interview on 2/14/25, at approximately 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training	F 0945		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
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F 0945  SS=E	Continued from page 157  on infection prevention and control program for six of nine staff members.  28 Pa Code: 201.14 (a) Responsibility of licensee.  28 Pa Code: 201.18 (b)(1) Management.  28 Pa Code: 201.20 (a)(c) Staff development.	F 0945		
F 0947  SS=F		F 0947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>231602</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
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F 0947  SS=F	Continued from page 158  483.95(g)(1)-(4) Required In-Service Training for Nurse Aides  §483.95(g) Required in-service training for nurse aides. In-service training must-  §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.  §483.95(g)(2) Include dementia management training and resident abuse prevention training.  §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff.  §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.  This REQUIREMENT is not met as evidenced by:	F 0947	No residents were affected by this deficiency.  All residents have the potential to be affected by this deficiency.  VP of Clinical Services provided education to the Administrator, Director of Nursing, and Humna Resources Director regarding the need to track 12 hours of annual training for certified nursing assistants. The facility has developed a tracking form to track these education hours for each nurse's aide.  The Human Resources Director will complete a monthly audit, on all employees due to complete their 12 hours of training that month ensure they have received the required 12 hours of training.  Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such a	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
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F 0947  SS=F	Continued from page 159	F 0947	time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
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F 0947  SS=F	Continued from page 160  Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to conduct at least 12 hours of in-service education, within 12 months of their hire date anniversary, for nurse aides as required for four of four nurse aides (Employee E1, E3, E4, and E5).  Findings include:  Review of the facility policy, "Training Requirements" most recently reviewed 10/20/24, indicated the facility will develop, implement, and maintain an effective training program for all new and existing staff.  Review of facility provided documents and training records revealed the following:  Nurse Aide (NA) Employee E1 had a hire date of 10/9/22. The facility provided education filed failed to have any dates or times provided on any documents within the file to confirm education	F 0947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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F 0947  SS=F	Continued from page 161  occurred between 10/9/23, through 10/9/24.  NA Employee E3 had a hire date of 10/11/04. The facility was unable to provide an education file or any other documentation that NA Employee E3 had completed any education from 10/11/23, through 10/11/24.  NA Employee E4 had a hire date of 10/11/05. The facility provided education filed revealed a "12-hour in-service packet," but no dates were present confirmed that the education occurred between 10/11/23, through 10/11/24.  NA Employee E5 had a hire date of 11/12/13. The facility provided education filed revealed a "12-hour in-service packet," but no dates were present confirmed that the education occurred between 11/12/23, through 11/12/24.  During an interview on 2/14/25, at approximately 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to conduct at least	F 0947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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F 0947  SS=F	Continued from page 162  12 hours of in-service education, within 12 months of their hire date anniversary, for nurse aides as required for four of four nurse aides.	F 0947		
F 0949  SS=E		F 0949		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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F 0949  SS=E	Continued from page 163  483.95(i) Behavioral Health Training  §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.71.  This REQUIREMENT is not met as evidenced by:	F 0949	No residents were affected by this deficiency.  All residents have the potential to be affected by this deficiency.  VP of Clinical Services, Administrator and Director of Nursing developed a facility Training Plan to include:  Effective communication for direct care staff.  Resident rights and facility responsibilities for caring of residents.  Elements and goals of the facility's QAPI program.  Written standards, policies, and procedures for the facility's infection prevention and control program.  Written standards, policies, and procedures for the facility's compliance and ethics program.	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
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F 0949  SS=E	Continued from page 164	F 0949	<p>Behavioral health.</p> <p>Dementia management and care of the cognitively impaired.</p> <p>Abuse, neglect, and exploitation prevention.</p> <p>Safety and emergency procedures.</p> <p>All staff will receive education in these areas, provided by the Administrator and Director of nursing or designee. Completed training will be signed and dated by staff after receiving the training. Moving forward staff will receive this training upon hire (during orientation) and annually.</p> <p>Human Resources Director will complete a weekly audit for 4 weeks on all new hires to ensure they have received the required trainings in the training plan and will complete a monthly audit that all staff have completed the assigned monthly</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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F 0949  SS=E	Continued from page 165	F 0949	<p>trainings to ensure continued annual training.</p> <p>Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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F 0949  SS=E	Continued from page 166  Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on behavioral health for seven of nine staff members (Employee E1, E3, E4, E6, E7, E8, and E9).  Findings include:  Review of the facility policy, "Training Requirements" most recently reviewed 10/20/24, indicated the facility will develop, implement, and maintain an effective training program for all new and existing staff. Training content includes, at a minimum: a. Effective communication for direct care staff. b. Resident rights and facility responsibility for caring of residents. c. Elements and goals of the facility's Quality Assurance and Performance Improvement program. d. Written standards, policies, and procedures for the facility's infection prevention and control program. e. Written standards, policies, and procedures for	F 0949		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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F 0949  SS=E	Continued from page 167  the facility's compliance and ethics program. f. Behavioral health. g. Dementia management and care of the cognitively impaired. h. Abuse, neglect, and exploitation prevention. i. Safety and emergency procedures.  Review of facility provided documents and training records revealed the following staff members did not have documented training on behavioral health.  Nurse Aide (NA) Employee E1 had a hire date of 10/9/22, failed to have behavioral health in-service education between 10/9/23, and 10/9/24.  NA Employee E3 had a hire date of 10/11/04, failed to have behavioral health in-service education between 10/11/23, and 10/11/24.  NA Employee E4 had a hire date of 10/11/05, failed to have behavioral health in-service education between 10/11/23, and 10/11/24.	F 0949		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>SQUIRREL HILL WELLNESS AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2025 WIGHTMAN STREET PITTSBURGH, PA 15217</b>		
STATE LICENSE NUMBER: <b>231602</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0949  SS=E	Continued from page 168  Environmental Services Employee E6 had a hire date of 9/18/20, failed to have behavioral health in-service education between 9/18/23, and 9/18/24.  Dietary Employee E7 had a hire date of 12/27/15, failed to have behavioral health in-service education between 12/27/23, and 12/27/24.  Licensed Practical Nurse Employee E8 had a hire date of 12/27/15, failed to have behavioral health in-service education between 12/27/23, and 12/27/24.  Maintenance Director Employee E9 had a hire date of 8/21/18, failed to have behavioral health in-service education between 8/21/23, and 8/21/24.  During an interview on 2/14/25, at approximately 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on infection prevention and control program for six of nine staff members.	F 0949		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>	
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F 0949  SS=E	Continued from page 169  28 Pa Code: 201.14 (a) Responsibility of licensee.  28 Pa Code: 201.18 (b)(1) Management.  28 Pa Code: 201.20 (a)(c) Staff development.	F 0949		

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P 1700	<p>Prevention, control and surveillance of tuber</p> <p>(b) Recommendations of the Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services (HHS) shall be followed in screening, testing and surveillance for TB and in treating and managing persons with confirmed or suspected TB.</p> <p>This REGULATION is not met as evidenced by:</p>	P 1700	<p>No residents were affected by pre-employment tuberculosis testing issues.</p> <p>Residents may be affected if practice does not change</p> <p>Human Resources will review employee files to ensure tuberculosis testing was completed On both employees Human Resources was educated by the director of nursing or designee on the pre-employment tuberculosis policy</p> <p>Director of nursing or designee will audit new hire charts for pre-employment tuberculosis testing weekly for 4 weeks for compliance.</p> <p>Findings will be reported to the quality assurance and process improvement meetings</p>	<p>Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b></p>

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

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395028</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/14/2025</b>
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P 1700	Continued from page 1  Based on review of Pennsylvania State regulations, Centers for Disease Control and Prevention (CDC) recommendations, facility policy, personnel records, and staff interview, it was determined that the facility failed to implement pre-employment screening procedures for tuberculosis (TB) for two of five newly hired employees (Employee E11 and E12).  Findings include:  Review of the Pennsylvania Department of Health Long Term Care Facility Regulations updated 1/13/25, previously dated 7/1/24, indicated "Recommendations of the Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services (HHS) shall be followed in screening, testing, and surveillance for TB and in treating and managing persons with confirmed or suspected TB."  Review of the CDC document, "Clinical Testing Guidance for Tuberculosis: Health Care Personnel" dated 12/15/23, indicated stipulates that all U.S.	P 1700		

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P 1700	Continued from page 2  health care personnel should be screened for TB upon hire (i.e., preplacement), and that a TB screening includes: -A baseline individual TB risk assessment, -TB symptom evaluation -A TB test (e.g., TB blood test or a TB skin test), and -Additional evaluation for TB disease as needed  Review of the CDC document, "Baseline Tuberculosis Screening and Testing for Health Care Personnel" dated 12/19/23, indicated -If baseline testing is performed using a TB blood test (also known as Interferon Gamma Release Assay or IGRA) two-step skin testing is not required. - If the Mantoux tuberculin skin test (TST) is used for baseline testing of health care personnel, use two-step testing.  Review of the facility policy, "Employee Tuberculosis Testing" dated 10/20/24, indicated New Staff Screening:	P 1700		

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P 1700	Continued from page 3  -At the time of employment, all new staff shall undergo pre-placement screening for TB, including an individual risk assessment, TB symptom screen, and a TB test. -All new staff shall receive two Mantoux TB Skin Tests given two weeks apart ("two-step testing") unless a previously positive TB skin test reaction or positive TB blood test is reported, tests) by a trained healthcare provider on our staff, or any licensed physician. -New staff with a documented history of a positive TB test shall be exempt from further TB testing. A chest radiograph (x-ray) will be required at the time of hire unless, within the last six (6) months, a chest radiograph with no evidence of active pulmonary disease can be documented.  Review of Environmental Services (EVS) Employee E11's personnel record indicated he was hired 12/23/24.  Review of EVS Employee E11's personnel record included only evidence of a one-step tuberculin skin	P 1700		

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P 1700	Continued from page 4  test.  Review of Registered Nurse Supervisor (RNS) Employee E12's personnel record indicated she was hired 2/3/25.  Review of EVS Employee E11's personnel record included only written evidence of prior positive tuberculin skin test, and documentation of a chest x-ray greater than one year prior to employment.  During an interview on 2/14/25, at approximately 2:00 p.m. the Nursing Home Administrator was made aware that the failed to implement pre-employment screening procedures for TB for two of five newly hired employees.	P 1700		
P 2170		P 2170		

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P 2170	Continued from page 5  Admission policy.  (e) The governing body of a facility shall establish written policies for the admissions process for residents, and through the administrator, shall be responsible for the development of and adherence to procedures implementing the policies. The policies and procedures shall include all of the following: (1) Introduction of residents to at least one member of the professional nursing staff for the unit where the resident will be living and to direct care staff who have been assigned to care for the resident. Prior to introductions, the professional nursing and direct care staff shall review the orders of the physician or other health care practitioner for the resident's immediate care. (2) Orientation of the resident to the facility and location of essential services and key personnel, including the dining room, nurses' workstations and offices for the facility's social worker and grievance or complaint officer. (3) A description of facility routines, including nursing shifts, mealtimes and posting of menus. (4) Discussion and documentation of the resident's customary routines and preferences, to be included in the care plan developed for the resident under 42 CFR 483.21 (relating to comprehensive person-centered care planning). (5) Assistance to the resident in creating a homelike environment and settling and securing personal possessions in the room to which the resident has been assigned.	P 2170	The facility orientation handbook was developed for Squirrel Hill Wellness and Rehab.  It was determined that not having the orientation could affect the new residents.  The handbook was given to Resident 212.  The Admissions Director was educated in giving the handbook to new residents.  The Director of nursing will interview 2 new admissions per week to see if they have received a copy of the handbook. once a week for 2 weeks then then every 2 weeks for 2 weeks then monthly for 2 months  The findings will be reported to the quality assurance and performance improvement committee.	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

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P 2170	Continued from page 6  This REGULATION is not met as evidenced by:	P 2170		

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P 2170	<p>Continued from page 7</p> <p>Based on a review of facility policy and clinical records, and staff interviews, it was determined that the facility failed to ensure that a resident was sufficiently oriented to the facility upon admission for one of three residents (Resident R212).</p> <p>Findings include:</p> <p>The facility "Admission of a Resident" policy dated 10/20/24, indicated a Resident handbook and/or Facility Orientation material should be provided to the resident/family prior to or upon admission.</p> <p>Review of Resident R212's admission record indicated the resident was admitted to the facility on 2/9/25 with diagnoses that included breast cancer, high blood pressure, and anxiety disorder.</p> <p>Review of Resident R212's clinical record did not indicate a Resident handbook and/or Facility Orientation material was provided to the resident/family prior to or upon admission.</p>	P 2170		

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P 2170	Continued from page 8  During an interview on 2/13/25, at 12:15 p.m. Resident R212 indicated they did not receive a resident handbook or facility orientation on admission.  During an interview on 2/12/25, at 11:00 a.m. Admission Director Employee E13 confirmed the above findings and that Resident R212's clinical record did not include evidence that the resident received admission information as required.  During an interview on 2/13/25, at 11:30 a.m. the Director of Nursing (DON) confirmed that the facility failed to ensure that Resident R212 was sufficiently oriented to the facility upon admission as required.	P 2170		
P 5520		P 5520		

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P 5520	Continued from page 9  Nursing services.  (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight.  This REGULATION is not met as evidenced by:	P 5520	No residents were affected during the day identified in 2567. The Director of Nursing and Staffing Coordinator was re-educated regarding staffing ratios for nursing assistants by the Administrator. The facility has previously reviewed the staffing plan and has assessed wages, provided extra shift pick up bonuses to qualified staff, provided flexible scheduling, and has advertised in several ways for staff including on online help wanted sites.  The facility will have each morning the administration staff meets to review the staffing for the day and any critical days in the future, weekly staffing meetings, staffing to include increased employees to cover for any call offs, progressive disciplinary action if necessary and weekly review of new staff that has been hired and will be joining the facility team in the future and any staff that has resigned or has been terminated. Corporate leadership included strategies and any needs of the facility. The	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>03/07/2025</b>

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P 5520	Continued from page 10	P 5520	Nursing Home Administrator, Director of Nursing, and Staffing Coordinator, or designees, will review the ratios daily and look ahead in the upcoming week schedule. The Director of Nursing or designee will monitor the rations 5 times a week for 4 weeks then weekly times 4. Results of audits will be reviewed at the facilities quality assurance performance improvement meeting.	

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P 5520	<p>Continued from page 11</p> <p>Based on review of nursing time schedules and staff interview it was determined that the facility administrative staff failed to provide a minimum of one nurse aide (NA) per 15 residents during the night shift for one of 21 days (2/8/25).</p> <p>Findings include:</p> <p>Review of the facility census data, nursing time schedules, and deployment sheets from 1/24/25 through 2/13/25, revealed the following nurse aide staffing shortages:</p> <p>On 2/8/25 the census was 67, which required 4.47 NAs during the night shift. Review of the nursing time schedules revealed 2.00 NAs provided care on the night shift. No additional excess higher-level staff were available to compensate this deficiency.</p> <p>During an interview on 2/12/25, at 11:00 a.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to provide a minimum of one nurse aide per 15 residents during the night shift for one of 21 days.</p>	P 5520		



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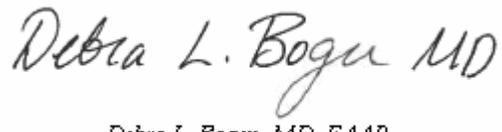
**SQUIRREL HILL WELLNESS AND REHABILITATION CENTER**

**STATE LICENSE NUMBER: 231602**

**SURVEY EXIT DATE: 02/14/2025**

**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, 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