STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395423	A. BLDG: 00 B. WING:	04/03/2025

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CORNER VIEW NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **060402**	**6655 FRANKSTOWN AVENUE PITTSBURGH, PA 15206**

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F 0000	INITIAL COMMENT Based on an abbreviated survey in response to three complaints completed on April 3, 2025, it was determined that Corner View Nursing and Rehabilitation Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0600 SS=J		F 0600		

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 0600 SS=J	Continued from page 1 483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 0600	Resident R1: was discharged to the hospital on 3/20/25 and will not return to the center. Resident R2: was assessed on 2/18/25 by nursing for any adverse effects of the alleged event and found no harm. Resident R2's responsible party and physician were contacted by nursing and sent to acute care hospital for in depth evaluation on 2/18/25. R2 returned to the facility on 2/18/25 with no new orders and found to be at baseline. Psych consulted and assessed on 2/19/25 with no negative findings. R3 was assessed by nursing on 3/20/25 for any adverse effects of the alleged event and found no harm. R3's responsible party and physician were contacted and Resident sent to acute care hospital for in depth evaluation by nursing on 3/20/25 for. Resident returned to the facility on 3/20/25 with no new orders and found to be at baseline.	Completion Date: **05/02/2025** Status: **APPROVED** Date: **04/22/2025**

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F 0600 SS=J	Continued from page 2	F 0600	Psychosocial assessments performed by Social Services with no negative findings. Psychological services were consulted. House education done by 4/3/25, by DON/Designee provided to all staff reviewing identifying types of abuse, anonymous reporting and reporting abuse. Megan law list check ran on all residents on 3/20/25, by DON/Designee. DON/Designee will audit all new admissions since 3/20/25, to ensure Megan law list checks were performed prior to admission. This was completed on 4/3/2025 by the DON. The DON/Designee was educated by the VP of Clinical Services on 4/2/25, on the use of the Sexual Activity Scale and interventions for residents who are identified to be high risk. The DON/Designee completed sexual activity scales on 4/2/25 on all	

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F 0600 SS=J	Continued from page 3	F 0600	residents as a tool to determine if any other residents pose a risk of engaging in unwanted sexual behaviors. Residents who score high risk on the sexual activity scale will have care plan and interventions updated as needed. No residents identified to be at high risk. The Directed In-Service will be presented to all staff by AAE Consulting Services for F600 Free from Abuse and Neglect on 5/1/25, with online video availability for any staff unable to attend the live sessions. Staff unable to attend will receive abuse education training prior to next scheduled shift. DON/Designee will perform Sexual Activity Scale tool on all new admissions and five random residents monthly x three months and as needed. The social services director/designee will interview 3 residents weekly x 4 weeks for abuse concerns.	

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F 0600 SS=J	Continued from page 4	F 0600	Policies on Abuse and Neglect were reviewed by the DON, NHA, and Medical Director and updated on 4/2/25. Observation and audit findings will be reviewed at the facility's monthly quality assurance meeting.	

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F 0600 SS=J	Continued from page 5 Based on review of facility policy, facility documentation, clinical records, and staff interviews, it was determined that the facility failed to protect Resident R3 with severe cognitive impairment from unwanted/non-consensual sexual contact by Resident R1 who had a history of sexually inappropriate behavior, including an unsolicited sexual contact with Resident R2 on February 18, 2025. This failure resulted in an Immediate Jeopardy situation when Resident R1 was found naked on top of Resident R3. (Resident R1, R2 and R3) Findings Include: Review of facility policy "Abuse, Neglect, Exploitation and Misappropriation Prevention Program" dated 2/3/25, indicated that residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to	F 0600		

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F 0600 SS=J	Continued from page 6 treat the resident's symptoms. Review of the facility policy "Care Plans, Comprehensive Person-Centered", dated 2/3/25, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition. b. when the desired outcome is not met. c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly assessment. Review of Resident R1's clinical record indicated that he was admitted to the facility on 12/6/19. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated	F 0600		

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F 0600 SS=J	Continued from page 7 2/19/25, indicated diagnoses of dementia (a decline in cognitive function that interferes with daily life), mood disorder (mental health condition that primarily affect emotional states), and paranoid schizophrenia (subtype of schizophrenia characterized by persistent paranoid delusions). Further review of MDS Section C- Cognitive Patterns, C0500 BIMS Summary Score indicate Resident R1 scored an "11", moderately impaired. Review of Resident R1's clinical progress note dated 2/18/25, at 10:46 a.m., stated a Nurse Aide (NA) reported that Resident R1 was in his room with female Resident R2. Evaluated situation, Resident R1 naked, with female Resident R2 naked from waist down, call placed to Supervisor and Administration. Review of facility documentation submitted 2/18/25, indicated that Resident R1 was seen sitting at bedside naked with Resident R2 in his bed naked. Staff told Resident R2 its time to get up, and Resident R1 became upset and told staff she is a	F 0600		

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F 0600 SS=J	Continued from page 8 grown women and can do what she wants. Resident R2 taken back to room, skin assessment completed with no injury notes, patient unable to recall or report pain. Resident R1 was placed on one to one. Review of facility documentation submitted witness statement by Nurse Aide (NA) Employee E2 dated 2/18/25, NA Employee E2 was looking for Resident R2 and when Employee E2 found her, she was in a males (R1) room, laying on his bed with her vagina visible and the gentleman (R1) attempting to cover her up with his blanket as to why he was naked on the side of the bed. Employee E2 got her (R2) up from his bed and reported incident to the nurse on the floor and she contacted the Director of Nursing (DON) and the Administrator (NHA). Review of Resident R1's clinical physician progress note dated 2/19/25, at 2:41 p.m., stated an immediate request to see patient because of an unwanted sexual encounter with another resident who is older and much more cognitively impaired. Patient has now become very agitated and	F 0600		

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F 0600 SS=J	Continued from page 9 aggressive when confronted; that he has been very mad all day and has been refusing his medications and meals. Patient is alert and oriented times two, and was in denial that any of this had happened; that all of the things staff were saying he did were not true; agreed that their allegations were bad things, but was adamant that he didn't do it and wouldn't ever do it again even if he did. Review of Resident R1's care plan on 4/2/25, indicated that on 2/18/25, his care plan was updated to include a problem focused on behavior due to sexual, combative and aggression towards staff and other residents; Care plan goal that Resident R1 will have fewer episodes of sexual, combative, aggression weekly. Further review of the care plan indicated that 15-minute checks for related sexual behavior was initiated on 2/18/25, and resolved 3/20/25. Further review of care plan failed to indicate that the facility developed appropriate care plan interventions to prevent further sexually inappropriate behaviors, specifically addressing supervision of Resident R1 and the safety of other	F 0600		

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F 0600 SS=J	Continued from page 10 residents from an alleged perpetrator of sexual abuse. Review of facility provided documentation revealed "Resident Observation q 15 Minute Checks Documentation" was initiated 10:00 a.m., on 2/18/25, and was stopped at 10:45 a.m., on 2/19/25. Interview conducted on 4/1/25, at 3:30 p.m., with Vice President of Clinical Operations (VP of Ops) Employee E1 revealed that every (q) 15 minute checks were stopped once Resident R1 was seen and evaluated by Psychiatric physician for follow-up which occurred 2/19/25, at 10:15 a.m. VP of Ops Employee E1 confirmed that facility failed to develop interventions after 2/18/25, event, that continually monitored and supervised Resident R1 behavior and actions towards others, to include cognitively impaired residents residing on unit. Review of Resident R2's clinical record indicated that she was admitted to the facility on 9/18/20.	F 0600		

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F 0600 SS=J	Continued from page 11 Review of Resident R2's Minimum Data Set dated 2/2/25, indicated diagnoses of Alzheimer's disease (chronic neurodegenerative condition that primarily affects memory, thinking, and behavior), dementia, and major depressive disorder (mental disorder characterized by persistent low mood, loss of interest or pleasure in activities, and a range of emotional and physical problems). Further review of MDS Section B- Hearing, Speech, and Vision, B0700 Makes Self Understood is coded "3", rarely/never understood; B0800 Ability to Understand Others is coded "3", rarely/never understands; Section C - Cognitive Patterns, C1000 Cognitive Skills for Daily Decision-Making is coded "3", severely impaired - never/rarely makes decisions. Section E - Behavior, E0900 Wandering - Presence and Frequency was coded "1", indicating behavior of this type occurred 1 to 3 days. Review of Resident R2's clinical progress note dated 2/18/25, at 10:54 a.m., stated Resident R2 was found in a male resident's room in bed, naked	F 0600		

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F 0600 SS=J	Continued from page 12 from the waist down. Evaluation done, no apparent injures, old scratches noted, Supervisor and ADON made aware. Review of Resident R2's clinical physician progress note dated 2/19/25, at 2:42 p.m., stated that today staff request for me to see patient; reported that she had a suspected sexual encounter with another resident who is much younger and much more cognitively intact. Review of facility submitted documentation on 2/18/25, indicated that female Resident R2 was evaluated at the hospital and placed on another unit. Family refused rape kit at hospital. Review of Resident R2's care plan dated 6/21/21, revised on 3/26/23, indicated that resident has impaired cognitive function/dementia or impaired thought processes regards to Alzheimer's, dementia. Intervention dated 6/21/21, included to cue, reorient, and supervise as needed. Further review of care plan dated 1/7/21, revised on 9/13/23,	F 0600		

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F 0600 SS=J	Continued from page 13 indicated that Resident R2 is an elopement risk/wanderer. Intervention dated 1/7/21, included to distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or books. Review of Resident R2's current care plan failed to indicate that her care and services was reviewed, updated, or revised to address alleged sexual abuse by another resident which occurred 2/18/25. Further review of Resident R1's clinical progress note dated 3/20/25, at 7:32 a.m., stated Resident R1 was found in his room on top of another female Resident R3. Orders received to send Resident R1 out to the hospital for further treatment and evaluation. Further review of Resident R1's clinical progress note dated 3/20/25, at 7:56 a.m., stated Resident R1 was found to have female Resident R3 in his room. She (R3) was caught in a sexual position under resident (R1).	F 0600		

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F 0600 SS=J	Continued from page 14 Review of Resident R3's clinical record indicated that she was admitted to the facility on 2/7/20. Review of Resident R3's Minimum Data Set dated 2/19/25, indicated diagnoses of dementia, major depressive disorder, and adult failure to thrive. Further review of MDS Section C - Cognitive Patterns, C0100 Should Brief Interview for Mental Status be conducted was coded "1", indicating that "yes" interview should be conducted. Section C0500 was coded "99", indicating Resident R3 was unable to complete interview. Section C1000, Cognitive Skills for Daily Decision Making was coded "3", indicating that Resident R3's cognition is "Severely impaired - never/rarely made decisions." Review of Resident R3's clinical progress note dated 3/20/25, at 6:04 a.m., stated resident (R3) was found across the hall in another resident's (R1) room. Resident (R3) was found by a Nurse Aide (NA) in a sexual position in resident's (R1) bed. She (R3) was encouraged to leave the room.	F 0600		

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F 0600 SS=J	Continued from page 15 Further review of Resident R3's clinical progress note dated 3/20/25, at 7:04 a.m., stated NA on duty immediately informed me Resident R3 was found in a room lying on B bed, the resident (R1) from B bed lying on top of her (R3). Resident R3 to be sent out to the hospital for further treatment and evaluation. Review of facility documentation submitted witness statement from NA Employee E3 dated 3/20/25, stated that Resident R3 was no longer in her bed when doing rounds, having just checked on her (R3) 15 minutes prior. Went to check in the male room (Resident R1's room) across the hall due to the fact that he had a situation in the past. Knocked on the door and witnessed the male resident (R1) on top of the female resident (R3). Resident R1 was told to get off of her (R3) and called for help. Resident R3 was taken to her room. Review of facility documentation initially submitted on 3/20/25, indicated that hospital records from	F 0600		

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F 0600 SS=J	Continued from page 16 Resident R3's encounter on 3/20/25, that patient was unable to tolerate any swab or internal exam of orifices, and this was subsequently deferred. Patient was seen by our discharge planning team to help with possible change in residency or going home, but for now family is comfortable the patient going back to the nursing care facility. The reported assailant is no longer at facility. Patient was overall at her usual state of health and was discharged from our facility. Review of Resident R3's care plan dated 3/1/25, revised 3/20/25, indicated that resident has a behavior problem attention seeks, flirtatious behavior, wanders in and out of other resident rooms regards to dementia, with goals for fewer episodes daily, and interventions to administer medications as ordered and monitor for side effects; anticipate and meet resident's needs; and caregivers to provide opportunity for positive interaction, attention: stop and talk with her as passing by. The Director of Nursing (DON), the Nursing Home	F 0600		

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F 0600 SS=J	Continued from page 17 Administrator (NHA), and the VP of Ops Employee E1 were made aware that an Immediate Jeopardy situation existed for residents on 4/2/25, at 10:03 a.m. and an immediate action plan was requested. On 4/2/25, at 10:03 a.m. the Immediate Jeopardy template was provided to the facility administration. On 4/2/25, at 6:08 p.m. an acceptable Corrective Action Plan was received which included the following interventions: Immediate Action: Resident R1: was discharged to the hospital and will not return to the center. Resident R2: was assessed by nursing for any adverse effects of the alleged event and found no harm. Resident R2's responsible party and physician were contacted. Resident sent to acute care hospital for in depth evaluation. Resident returned to facility with	F 0600		

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F 0600 SS=J	Continued from page 18 medication and found to be at baseline. Psych consulted and assessment performed. Education and observations are ongoing to ensure residents are secure and safe. Resident R3: was assessed for any adverse effects of the alleged event and found no harm. Resident R3's responsible party and physician were contacted Resident sent to acute care hospital for in depth evaluation. Resident returned to facility with medication and found to be at baseline. Psychosocial assessments performed with negative findings. Psychological services were consulted and assessment performed. Education and observations are ongoing to ensure residents are secure and safe. Root cause analysis identified that facility failed to provided adequate supervision to the alleged perpetrator. Actions taken to identify any residents with sexual behaviors: House education done by 4/3/25, by DON/Designee provided to all staff reviewing	F 0600		

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F 0600 SS=J	Continued from page 19 identifying type of abuse, anonymous reporting and reporting abuse. Megan law list check ran on all residents on 3/20/25, by DON/Designee. DON/Designee will audit all new admissions since 3/20/25, to ensure Megan law list checks were performed prior to admission. This will be completed by 4/3/2025. The DON/Designee was educated by the VP of Clinical Services on 4/2/25, on the use of the Sexual Activity Scale and interventions for residents who are identified to be high risk. The DON/Designee will perform sexual activity scale on all residents as a tool to determine if any other residents pose a risk of engaging in unwanted sexual behaviors by 4/3/25. Residents who score high risk on the sexual activity scale will have care plan and interventions updated as needed. DON/Designee will perform Sexual Activity Scale tool on all new admissions and five random residents monthly times three months and as needed.	F 0600		

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F 0600 SS=J	Continued from page 20 Policies on Abuse and Neglect were reviewed by the DON, NHA, and Medical Director and updated on 4/2/25. Observation and audit findings will be reviewed at the facility's monthly quality assurance meeting. Immediate Jeopardy was lifted on 4/3/25, at 3:04 p.m., and the abatement plan was verified as follows: Immediate actions verified. Resident interviews were reviewed, and it was verified that 159 of 159 residents were interviewed to determine whether they had knowledge of sexually inappropriate behaviors amongst residents, if they feel safe, and if they know how to report concerns. Root cause analysis identified that facility failed to provide adequate supervision to the alleged perpetrator. Facility identified 185 staff members from all	F 0600		

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F 0600 SS=J	Continued from page 21 departments. Staff interviews completed. 22 of 22 clinical staff members and 43 of 43 non-clinical staff interviewed in person and training was verified as completed and content understood. A total of 65 of 65 in-house staff present in facility were verified as trained. 100% of staff on-site have been verified as receiving abuse training. 129 staff members were verified as having received abuse training via in-person signatures. Two of five staff members answered telephonic communication and verified that training was received and understood via phone; three of five were left voicemails to return call. All staff unaccounted for at this time will receive and sign abuse education training prior to next scheduled shift. Review of Megan's Law check completed on 3/20/25, was verified for 163 of 163 residents. Review of new admissions from 3/20/25, verified	F 0600		

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F 0600 SS=J	Continued from page 22 that ten of ten residents Megan's Law checks were completed. Review of Clinical Education Services form verified that VP of Clinical Services completed education to the DON on the Sexual Activity Scale (SAS) tool and interventions for residents who are identified to be high risk on 4/2/25. Sexual Activity Scale tool was completed as of 4/3/25, for 152 of 152 residents. There were no new residents identified as high risk. Review of audit tool for future monitoring of Sexual Activity Scale tool completion confirmed. Revised Abuse policy was verified as updated of 4/3/25. The change made to the policy "Residents have the right to engage in sexual activity. However, anytime there is a reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility will take steps to ensure that the resident is protected from abuse, including evaluating whether the resident has the capacity to	F 0600		

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F 0600 SS=J	Continued from page 23 consent to sexual activity." Next facility QAPI meeting scheduled on April 16, 2025. During an interview on 4/3/25, at 3:10 p.m., information was disseminated to the Nursing Home Administrator (NHA) and VP of Ops Employee E1 that the facility failed to protect Resident R3 with severe cognitive impairment from unwanted/non-consensual sexual contact by Resident R1 who had a history of sexually inappropriate behavior, including an unsolicited sexual contact with Resident R2 on February 18, 2025. This failure resulted in an Immediate Jeopardy situation when Resident R1 was found naked on top of Resident R3, and because this type of inappropriate, unwanted sexual contact would reasonably cause anyone to have psychosocial harm, it can be determined that the reasonable person in these residents' position would have experienced severe psychosocial harm- dehumanization, and humiliation- as a result of the	F 0600		

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F 0600 SS=J	Continued from page 24 sexual abuse. (Resident R2 and R3) 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10 (d) Resident care policies	F 0600		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 25 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	R1 has been discharged-no care plan update can be completed R2's care plan was updated by facility RN on 4/17/24 to include suspected sexual encounter with another resident. All residents with suspected abuse have the potential to be affected. The DON/Designee will do a 60-day look back at the ERS system to ensure that care plans were updated for residents with suspected or confirmed abuse. The initial audit will be completed by 4/25/25. Identified Issues will be corrected at the time of the initial audit. The facilities Unit Managers will be educated by the DON on the facility policy for Care Plans, Comprehensive Person-Centered by 4/25/25 The DON/Designee will audit the ERS system weekly x 4 weeks to ensure care plan updates are completed for residents with	Completion Date: **05/06/2025** Status: **APPROVED** Date: **04/22/2025**

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F 0657 SS=D	Continued from page 26	F 0657	suspected or confirmed abuse. Observation and audit findings will be reviewed at the facility's monthly quality assurance meeting.	

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F 0657 SS=D	Continued from page 27 Based on review of facility policy, clinical records, and staff interview, it was determined the facility failed to ensure that residents' comprehensive care plans were reviewed and revised as needed to accurately reflect their current needs and services required by two of three residents sampled (Residents R1, and R2). Findings include: Review of the facility policy "Care Plans, Comprehensive Person-Centered", dated 2/3/25, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and	F 0657		

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F 0657 SS=D	Continued from page 28 d. at least quarterly, in conjunction with the required quarterly assessment. Review of Resident R1's clinical record indicated that he was admitted to the facility on 12/6/19. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/19/25, indicated diagnoses of dementia (a decline in cognitive function that interferes with daily life), mood disorder (mental health condition that primarily affect emotional states), and paranoid schizophrenia (subtype of schizophrenia characterized by persistent paranoid delusions). Further review of MDS Section C- Cognitive Patterns, C0500 BIMS Summary Score indicate Resident R1 scored an "11", moderately impaired. Review of Resident 1's clinical progress note dated 2/18/25, at 10:46 a.m., stated a Nurse Aide (NA) reported that resident [R1] was in his room with female resident. Evaluated situation, resident [R1] naked, with female resident naked from waist down,	F 0657		

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F 0657 SS=D	Continued from page 29 call placed to Supervisor and Administration. Review of Resident R1's clinical physician progress note dated 2/19/25, at 2:41 p.m., stated an immediate request to see patient because of an unwanted sexual encounter with another resident who is older and much more cognitively impaired. Review of Resident R1's care plan on 4/2/25, indicated that on 2/18/25, his care plan was updated to include a problem focused on behavior due to sexual, combative and aggression towards staff and other residents; Care plan goal that Resident R1 will have fewer episodes of sexual, combative, aggression weekly. Further review of the care plan failed to indicate that the facility developed appropriate care plan interventions to prevent further sexually inappropriate behaviors, specifically addressing supervision of Resident R1 and the safety of other residents from an alleged perpetrator of sexual abuse. Review of Resident R2's clinical record indicated	F 0657		

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F 0657 SS=D	Continued from page 30 that she was admitted to the facility on 9/18/20. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/2/25, indicated diagnoses of Alzheimer's disease (chronic neurodegenerative condition that primarily affects memory, thinking, and behavior), dementia, and major depressive disorder (mental disorder characterized by persistent low mood, loss of interest or pleasure in activities, and a range of emotional and physical problems). Further review of MDS Section B- Hearing, Speech, and Vision, B0700 Makes Self Understood is coded "3", rarely/never understood; B0800 Ability to Understand Others is coded "3", rarely/never understands; Section C - Cognitive Patterns, C1000 Cognitive Skills for Daily Decision Making is coded "3", severely impaired - never/rarely makes decisions. Review of Resident R2's clinical progress note dated 2/18/25, at 10:54 a.m., stated resident [R2] was found in a male residents room in bed, naked	F 0657		

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F 0657 SS=D	Continued from page 31 from the waist down. Evaluation done, no apparent injures, old scratches noted, Supervisor and ADON made aware. Review of Resident R2's clinical physician progress note dated 2/19/25, at 2:42 p.m., stated that today staff request for me to see patient; reported that she had a suspected sexual encounter with another resident who is much younger and much more cognitively intact. Review of Resident R2's current care plan failed to indicate that her care and services was reviewed, updated, or revised to address alleged sexual abuse by another resident. During an interview on 4/3/25, at 3:10 p.m., the Nursing Home Administrator (NHA) and Vice President of Clinical Operations (VP of Clinical Ops) confirmed that the facility failed to ensure that residents' comprehensive care plans were reviewed and revised as needed to accurately reflect their current needs and services for two of three residents	F 0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CORNER VIEW NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **060402**	**6655 FRANKSTOWN AVENUE PITTSBURGH, PA 15206**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0657 SS=D	Continued from page 32 (Resident R1 and R2) after an alleged incident of sexual abuse. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.	F 0657		
F 0835 SS=F		F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0835 SS=F	Continued from page 33 483.70 Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 0835	The facility Administrator and Director of Nursing will review and sign their job descriptions by 4/25/25. The Administrator and Director of Nursing will be educated by the VP of Clinical Services on effectively managing the facility to make certain that necessary care and services were and will be provided to residents to ensure residents are free from abuse by 4/25/25. The Administrator and Director of Nursing will educate all staff on reporting any suspicions, signs, or symptoms of abuse immediately to NHA or DON. Also, on the ability to report anonymously through the compliance line. The DON/Designee will quiz 3 employees weekly x 4 weeks on types of abuse and abuse reporting. The Social Services Director/designee will interview 3 residents weekly x 4 weeks for abuse	Completion Date: **05/06/2025** Status: **APPROVED** Date: **04/22/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0835 SS=F	Continued from page 34	F 0835	concerns. This plan of correction will be monitored at the monthly Quality Assurance meeting until substantial compliance has been met.	

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F 0835 SS=F	Continued from page 35 Based on review of job descriptions, clinical records, and staff interviews, it was determined that the Nursing Home Administrator and Director of Nursing did not effectively manage the facility to make certain that necessary care and services were provided to residents to prevent sexual abuse for 2 of 2 residents (Resident R2 and R3), which created an immediate jeopardy situation for all 152 of 152 residents. Findings include: Review of CFR §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The job description for the Nursing Home Administrator (NHA) specified the responsibility for overseeing the daily operation of the nursing facility, ensuring compliance with Pennsylvania state laws, Medicare/Medicaid, and federal regulations. This	F 0835		

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F 0835 SS=F	Continued from page 36 role involves managing staff, coordinating patients care, maintaining financial stability, and upholding the highest standards of resident care and safety. The job description of the Director of Nursing (DON) specified the responsibility to plan, organize, develop and direct the overall operation of the Nursing Services Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern the facility, and as may be directed by the Administrator and the Medical Director, to ensure that the highest degree of quality care is maintained at all times. Based on findings in the report, the facility failed to protect Resident R1 and Resident R2 from sexual abuse, which placed the residents in Immediate Jeopardy. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 4/3/25, at 3:10 p.m., the NHA and DON confirmed that they failed to	F 0835		

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F 0835 SS=F	Continued from page 37 effectively manage the facility to prevent sexual abuse for 2 of 2 residents (Resident R2 and R3). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.	F 0835		

Certified End Page

CORNER VIEW NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 060402

SURVEY EXIT DATE: 04/03/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

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

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

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