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:	12/23/2025

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 0000	INITIAL COMMENT Based on an abbreviated survey in response to one complaint completed on December 23, 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 0686 SS=D		F 0686		

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 0686 SS=D	Continued from page 1 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	R1 has discharged from this facility. 7 Day look back audit will be completed on wound dressing doucmentation to ascertain no other residents were affected. DON will educate Wound Nurse and Nursing Staff on facility wound care policy. DON/Designee will audit wound dressing documentation weekly x 2 to enusre documentation is completed. Results of these audits will be reviewed in the Quality Improvement Committe for reccomendations as needed.	Completion Date: **01/09/2026** Status: **APPROVED** Date: **01/02/2026**

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F 0686 SS=D	Continued from page 2 Based on review of facility policies, clinical records, facility documents and staff interviews, it was determined that the facility failed to ensure residents were assessed, and provided necessary treatment and services, consistent with professional standards of practice, for a pressure ulcer (PU/PIs- injuries to skin and underlying tissue resulting from prolonged pressure on the skin) for one of three residents (Resident R1). Findings include: Review of facility policy "Wound Care" dated 10/30/25, indicated the purpose is to provide guidelines for the care of wounds to promote healing. Verify that there is a physician's order for the procedure. Review the resident's care plan to assess for any special needs of the resident. The following information should be recorded in the resident's medical record: Type of wound care given.The date and time the wound care was given. The position in which the resident was placed. The name and title of the	F 0686		

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F 0686 SS=D	Continued from page 3 individual performing the wound care. Any changes in the resident's condition.All assessment data (i.e., wound bed color, size, drainage, etc) obtained when inspecting the wound. How the resident tolerated the procedure. Any problems or complaints made by the resident related to the procedure. In the resident refused the treatment and the reason(s) why.The signature and title of the person recording the data. Review of the clinical record indicated Resident R1 was admitted to the facility on 10/19/25, recently readmitted 11/6/25. Review of Resident R8's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/8/25, indicated diagnoses metabolic acidosis (condition characterized by an excess of acid on the blood), pulmonary embolism (condition that occurs when a blood clot blocks blood flow the lungs), and high blood pressure. Section M - Skin Condition, M0300C indicated a "1" = Number of Stage 3 pressure ulcers, and M0300D indicated a "1" =	F 0686		

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F 0686 SS=D	Continued from page 4 Number of Stage 4 pressure ulcers. Review of Resident R1's clinical Skin/Wound progress note dated 12/15/25, revealed that Left gluteal fold is a Stage 3 Pressure ulcer, not healed, measurements 0 cm (centimeters) length x 0 cm width, and with no measurable depth, area closed, wound is improving; Right gluteal fold is a Stage 4 Pressure ulcer, not healed, measurements 5.4 cm length, 4.7 cm width, and 0.5 cm depth, wound is improving. Resident of Resident R1's physician order dated 11/7/25, discontinued 12/16/25, indicated to cleanse left ischial with NSS (normal saline solution = sterile water), pat dry, apply Medihoney (medical grade honey product that supports wound healing) and cover with a dry dressing daily and PRN (as needed) for soilage and/or dislodgement every day shift for wound care. Review of an additional physician order dated 11/23/25, discontinued 12/16/25, indicated to	F 0686		

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F 0686 SS=D	Continued from page 5 cleanse right ischial with NSS, pat dry, apply calcium alginate (wound care product derived from seaweed to enhance autolytic debridement) and cover with a dry dressing daily and PRN for soilage and/or dislodgement every day shift for wound care. Review of Resident R1's current plan of care for pressure areas, initiated 11/7/25, indicated to administer treatments as ordered and monitor for effectiveness Review of Resident R1's Treatment Administration Record (TAR) from 12/1/25, through 12/16/25, revealed no documentation of refusals of dressing changes and revealed the following dates without wound treatment documented as completed: 12/3/25, 12/9/25, 12/10/25, 12/11/25, 12/12/25, 12/14/25, and 12/15/25 Review of Resident R1's s progress notes failed to reveal documentation of a reason for the dressings not to have been completed.	F 0686		

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F 0686 SS=D	Continued from page 6 During an interview on 12/23/25, at 1:00 p.m., the Director of Nursing (DON) confirmed that dressing changes for Resident R1 were not documented as completed and revealed that the wound nurse may have been off and/or pulled to a cart to pass medication, and coverage for daily wound care was not communicated effectively to staff for coverage. During an interview on 12/23/25, at 2:20 p.m., the Nursing Home Administrator (NHA) and the DON confirmed that the facility failed to ensure residents were assessed, and provided necessary treatment and services, consistent with professional standards of practice, for a pressure ulcer (PU/PIs- injuries to skin and underlying tissue resulting from prolonged pressure on the skin) for one of three residents (Resident R1). 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.	F 0686		

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F 0686 SS=D	Continued from page 7	F 0686		

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P 5520	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	NHA will educate DON/Scheduler on minimum staffing hours/regulations on new staffing guidelines effective July 1, 2024. Facility has advertised for open CNA positions. Interviews will be conducted as applicatns apply. Open interviews have been scheduled for every Thursday in January 2026, 10am to 2pm. Scheduler will meet daily with NHA/DON/Designee to review staffing schedule for a period of 2 weeks to ensure CNA ratios are being met. Scheduler will continue to monitor CNA ratios to ensure facility has sufficient staffing. Results of these audits will be reviewed in the Quality Improvement Committe for recommendations as needed.	Completion Date: **01/09/2026** Status: **APPROVED** Date: **01/02/2026**

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

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P 5520	Continued from page 1 Based on review of nursing time schedules and staff interviews, it was determined that the facility administrative staff failed to provide a minimum of one nurse aide (NA) per 10 residents during the day shift for five of 21 days (12/2/25, 12/11/25, 12/13/25, 12/14/25, and 12/21/25), one nurse aide per 11 residents on evening shift for two of 21 days (12/10/25, and 12/22/25), and one nurse aide per 15 residents on the overnight shift for ten of 21 days (12/4/25, 12/5/25, 12/10/25, 12/12/25, 12/13/25, 12/14/25, 12/15/25, 12/18/25, 12/19/25, and 12/22/25). Findings include: Review of facility census data and nursing time schedules from 12/2/25 through 12/22/25, revealed the following NA staffing shortages: Day Shift: DateCensusFull Time Equivalents (FTE) PresentFTE Required 12/2/25 153 14.40 15.30	P 5520		

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P 5520	Continued from page 2 12/11/25 162 16.00 16.20 12/13/25 162 14.93 16.20 12/14/25 162 13.44 16.20 12/21/25 161 14.93 16.10 Evening Shift: Date Census FTE Present FTE Required 12/10/25 161 13.60 14.64 12/22/25 165 14.93 15.00 Night Shift: Date Census FTE Present FTE Required 12/4/25 159 9.60 10.60 12/5/25 159 9.60 10.60 12/10/25 161 10.00 10.73 12/12/25 160 10.00 10.67 12/13/25 162 7.47 10.80 12/14/25 162 10.67 10.80 12/15/25 161 8.53 10.73 12/18/25 161 10.67 10.73 12/19/25 161 9.60 10.73 12/22/25 165 8.53 11.00	P 5520		

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P 5520	Continued from page 3 During an interview on 12/23/25, at 2:30 p.m., the Nursing Home Administrator (NHA) confirmed that the facility administrative staff failed to provide a minimum of one nurse aide (NA) per 10 residents during the day shift for five of 21 days, one nurse aide per 11 residents on evening shift for two of 21 days, and one nurse aide per 15 residents on the overnight shift for ten of 21 days as required with no additional excess higher-level staff to compensate this deficiency.	P 5520		
P 5530		P 5530		

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P 5530	Continued from page 4 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	NHA will educate DON/Scheulder on minimum staffing hours/regulations on new staffing guidelines effective July 1, 2024. Facility has advertised for open LPN positions. Interviews will be conducted as applicants apply. Open interviews have been scheduled for every Thursday in January 2026, 10 am to 2pm. Scheduler will meet dailiy with NHA/DON/Designee to review staffing schedule for a period of 2 weeks to ensure LPN ratios are being met. Scheduler will continue to monitor LPN ratios to ensure facility has sufficient staffing. Results of these audits will be reviewed in the Quality Improvement Committee for recommendations as needed.	Completion Date: **01/09/2026** Status: **APPROVED** Date: **01/02/2026**

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P 5530	Continued from page 5 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 licensed practical nurse (LPN) per 25 residents during the daylight shift on seven of 21 days (12/5/25, 12/7/25, 12/8/25, 12/13/25, 12/14/25, 12/16/25, and 12/21/25) and one LPN per 35 residents during the evening shift on two of 21 days (12/14/25, and 12/19/25). Findings include: Review of facility census data and nursing time schedules from 12/2/25, through 12/22/25, revealed the following LPN staffing shortages. Daylight Shift: Date Census Full Time Equivalents (FTE) Present FTE Required 12/5/25 159 5.33 6.36 12/7/25 159 5.87 6.36 12/8/25 157 5.33 6.28 12/13/25 162 6.40 6.48	P 5530		

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P 5530	Continued from page 6 12/14/25 162 5.33 6.48 12/16/25 161 6.40 6.44 12/21/25 161 5.33 6.44 Evening Shift: Date Census FTEs Present FTE Required 12/14/25 162 4.27 5.40 12/19/25 161 5.33 5.37 During an interview on 12/23/25, at 2:30 p.m. the Nursing Home Administrator (NHA) confirmed the staffing shortages and that the facility failed to provide one LPN per 25 residents during the daylight shift on seven of 21 days and one LPN per 35 residents during the evening shift on two of 21 days as required with no additional excess higher-level staff to compensate this deficiency.	P 5530		

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P 5640	Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	NHA will educate DON/Scheduler on minimum stffing hours/regulations on new staffing guidelines effective July 1, 2024. Facility has advertised for open nursing care posiyions. Interviews will be conducted as applicants apply. Open interviews have been scheduled for every Thursday in January 2026, 10 am to 2pm. Scheduler will meet dailiy with NHA/DON/Designee to review staffing schedule for a period of 2 weeks to enusre facility is providing the minimum genreal nursing hours to each resident. Scheduler will calcualte HPPD throughout the day to ensure facility has sufficient staff. Results of these audits will be reviewed in the Quality Improvement Committee for recommendations as needed.	Completion Date: **01/09/2026** Status: **APPROVED** Date: **01/02/2026**

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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
P 5640	Continued from page 8 Based on review of nursing time schedules and staff interviews it was determined that the facility administrative staff failed to provide the minimum number of general nursing hours to each resident in a 24 hour period on 16 of 21 days (12/2/25, 12/4/25, 12/5/25, 12/7/25, 12/10/25, 12/11/25, 12/12/25, 12/13/25, 12/24/25, 12/15/25, 12/16/25, 12/18/25, 12/19/25, 12/20/25, 12/21/25, and 12/22/25). Findings include: Review of facility census data and nursing time schedules from 12/2/25, through 12/22/25, revealed that the facility failed to maintain 3.20 hours of general nursing care (PPD) to each resident in a 24-hour period on the following dates: DateCensusPPD 12/2/25 153 3.10 12/4/25 159 3.16 12/5/25 159 3.12 12/7/25 159 3.18	P 5640		

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:	12/23/2025

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P 5640	Continued from page 9 12/10/25 161 3.03 12/11/25 162 3.08 12/12/25 160 3.09 12/13/25 162 2.77 12/14/25 162 2.81 12/15/25 161 3.06 12/16/25 161 3.05 12/18/25 161 3.18 12/19/25 161 2.93 12/20/25 161 3.05 12/21/25 161 2.96 12/22/25 165 2.93 During an interview on 12/23/25, at 2:30 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to provide the minimum number of general nursing hours to each resident in a 24-hour period on 16 of 21 days as required.	P 5640		

Certified End Page

CORNER VIEW NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 060402

SURVEY EXIT DATE: 12/23/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

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

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY