STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395666	A. BLDG: 00 B. WING:	12/27/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SPRING HILL REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **192902**	**2170 RHINE STREET** **PITTSBURGH, PA 15212**

(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 two complaints, completed on December 27, 2024, it was determined that Spring Hill Rehabilitation and Nursing 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 0584 SS=E		F 0584		

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 0584 SS=E	Continued from page 1 483.10(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; §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	F 0584	1. Linen supply was dispersed into rotation and rooms 224, 225, and 226 were cleaned the same date, 12/27/24. Residents had no negative outcomes. 2. NHA/designee will educate Plant Operations Manager on linen supply, correct par levels, and maintaining a clean, safe, and homelike environment for resident rooms. 3. Linen supply will be audited for ample supply/par level by Plant Operations Manager/designee 1x/week for 4 weeks, then 1x/month for 2 months. 4. Resident rooms will be audited to maintain clean, safe, and homelike environment by Plant Operations Manager/designee 1x/week for 4 weeks, then 1x/month for 2 months. 5. Results to be submitted to QAPI for review and approval.	Completion Date: **02/15/2025** Status: **APPROVED** Date: **01/22/2025**

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 0584 SS=E	Continued from page 2 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 3 Based on observation, and staff interview, it was determined that the facility failed to maintain a clean, safe, and homelike environment for three of three resident rooms (Rooms 224, 225, and 226), and failed to have an ample supply of linen at the staff's immediate disposal on four of five hallways (2East, 2West, 1 East, and 1West). Findings Include: Review of the facility policy "Safe and Homelike Environment" dated 12/9/24, indicated in accordance with resident's rights, the facility will provide a safe, clean, comfortable, and homelike environment. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment. The facility will provide and maintain bed and bath linens that are clean and in good condition. During observations of the Second-floor nursing unit on 12/27/24, at 9:28 a.m. the following was observed:	F 0584		

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F 0584 SS=E	Continued from page 4 -the Second-floor nursing unit found 12 allocated beds not prepared for resident use as follows: -Room 224 indicated four bed frames in disrepair with headboards and foot boards removed and air mattresses on the floor. -Room 225 indicated six headboards and bulletin boards on the floor, air mattress on one bed-stained brown in the center, a cart with side rail and bed parts and a can of interior primer paint, metal mesh like vent on bedside stand, and debris throughout the room. -Room 226 indicated three head and foot boards resting on a bed, one bed frame without a mattress, air mattresses on the floor and a flat screen TV faced down on the bedside stand, a PTAC unit (packaged terminal air conditioner that heats and cools small areas) with the unit's face removed, exposing the inside. Observation on 12/27/24, at 9:08 a.m. indicated Nurse Aide (NA) Employee E1 with a bottle of soda in hand walking up and down the hallways.	F 0584		

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F 0584 SS=E	Continued from page 5 Interview on 12/27/24, at 9:30 a.m. NA Employee E1 indicated she was looking for linen and that the staff did not have enough washcloths and towels. Observation on 12/27/24, at 9:31 a.m. 2West had zero wash cloths and zero towels available for staff use. Observation on 12/27/24, at 9:32 a.m. 2East had one wash cloth and zero towels available for staff use. Interview on 12/27/24, at 9:35 a.m. Licensed Practical Nurse (LPN) Employee E2 confirmed the lack of wash cloths and towels and indicated the facility is constantly running out of linen. Observation on 12/27/24, at 9:41 a.m. 1West had zero wash cloths and three towels available for staff use. Observation on 12/27/24, at 9:42 a.m. 1East had zero wash cloths and zero towels available for staff	F 0584		

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F 0584 SS=E	Continued from page 6 use. Interview on 12/27/24, at 9:43 a.m. Registered Nurse (RN) Employee E3 confirmed the lack of wash cloths and towels and indicated the facility runs out of linens frequently. Interview on 12/27/24, at 9:50 a.m. Environmental Services Employee E4 indicated the facility had cases of wash cloths about four to six weeks ago and they are just gone. Interview on 12/27/24, at 2:30 p.m. the Nursing Home Administrator confirmed the facility failed to maintain a clean, safe, and homelike environment for three of three resident rooms (Rooms 224, 225, and 226), and failed to have an ample supply of linen at the staff's immediate disposal on four of five hallways (2East, 2West, 1 East, and 1West). 28 Pa. code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (e)(1)(2) Management.	F 0584		

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F 0584 SS=E	Continued from page 7 28 Pa Code: 201.29 (a)(c)(d) Resident Rights.	F 0584		
F 0620 SS=D	483.15(a)(1)-(7) Admissions Policy §483.15(a) Admissions policy. §483.15(a)(1) The facility must establish and implement an admissions policy. §483.15(a)(2) The facility must- (i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and (ii) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits. (iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property. §483.15(a)(3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign	F 0620	1. Resident CR1 did not experience any negative outcomes. 2. An audit of admissions over the past 3 months will be conducted to determine if there are any residents with like clinical capabilities. 3. Facility's clinical capabilities were reviewed and updated. 4. Admissions team will be educated on updated clinical capabilities. 5. New admissions will be audited by DON/designee 2x/week for 3 weeks to monitor reasonable accommodations. 6. Results reported to QAPI for review and approval.	Completion Date: **02/15/2025** Status: **APPROVED** Date: **01/21/2025**

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F 0620 SS=D	Continued from page 8 a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources. §483.15(a)(4) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,- (i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and (ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident. §483.15(a)(5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.	F 0620		

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F 0620 SS=D	Continued from page 9 §483.15(a)(6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility. §483.15(a)(7) A nursing facility that is a composite distinct part as defined in §483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section. This REQUIREMENT is not met as evidenced by:	F 0620		

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F 0620 SS=D	Continued from page 10 Based on review of facility policy, resident records, admission documentation and staff interview it was determined that the facility failed to disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility for one of three residents (Closed Resident Record CR1). Findings include: Review of the facility policy "Admission" dated 12/9/24, indicated a nursing facility must disclose and provide to a resident or potential resident, prior to time of admission, notice of special characteristics or service limitations of the facility. Review of the hospital referral for Resident CR1 indicated resident with suspect mild to moderate Alzheimer's dementia (a progressive disease that destroys memory and other important mental functions), delirium (serious disturbance in mental abilities that results in confused thinking and reduced awareness of surroundings) precautions.	F 0620		

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F 0620 SS=D	Continued from page 11 Further review of the hospital referral for Resident CR1 dated 12/13/24, at 1:41 p.m. indicated a consult for rapidly progressive dementia. On the evening of 12/11/24, a crisis response was called as patient was wandering the hospital halls and walking into other patient rooms. Resident CR1 is known to the Neurology Group after an emergency room visit for altered mental status in June 2024, where she was found wandering and confused walking around PNC Park. She is paranoid, has become verbally aggressive and combative towards others, and has visual hallucinations of adults and children in her home at times. Review of progress notes dated 12/19/24, at 6:23 p.m. indicated Resident CR1 arrived at the facility in an ambulance. Once in building she indicated she was supposed to be going to the Giant Eagle. Refused to go to her room. Resident is alert to self and disoriented to place and time. Resident is delusional and refusing food.	F 0620		

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F 0620 SS=D	Continued from page 12 Review of progress notes dated 12/19/24, at 8:00 p.m. indicated Emergency Medical Services (EMS) and an EMS physician on site to evaluate Resident CR1 and agreed Resident R1 should return to the Emergency Room. Resident R1 refused to go with EMS in fear they are not who they say they are. Family notified and agreed to come and accompany her back to the hospital. Interview on 12/27/24, at 11:00 a.m. the Nursing Home Administrator and Director of Nursing indicated Resident CR1 was never admitted to the facility, although she was in the facility for over an hour and a half, and they were unaware of her behavioral history, and that the facility failed to disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility for one of three residents (Resident CR1). 28 Pa. Code: 201.14(a) Responsibility of Licensee.	F 0620		

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F 0620 SS=D	Continued from page 13 28 Pa Code: 201.18 (e)(1)(2) Management. 28 Pa. Code: 201.20(c) Staff Development. 28 Pa Code: 201.29 (a)(c)(d) Resident Rights.	F 0620		

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H 0005	51.3 (c) NOTIFICATION 51.3 Notification (c) A health care facility shall provide similar notice at least 60 days prior to the effective date it intends to cease providing an existing health care service or reduce it licensed bed complement. This REGULATION is not met as evidenced by:	H 0005	1. Rooms 224, 225 and 226 were cleaned and beds were assembled the same day, 12/27/2024. 2. Residents had no negative outcomes. 3. Temporary Restriction on 12 beds in rooms 224, 225, and 226 has been submitted to Department of Health on 1/13/2025. 4. Rooms 224, 225, and 226 will be audited by Plant Operations Manager/designee 1x/week for 3 weeks. 5. Results reported to QAPI for review and approval.	Completion Date: **02/15/2025** Status: **APPROVED** Date: **01/21/2025**

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

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H 0005	Continued from page 1 Based on facility records, observations and staff interview it was determined that the facility failed to provide notification to the department that it had reduced the number of licensed beds in operation. Findings include: The facility bed readout document (a document showing the number of beds licensed in the facility) indicated Medicare/Medicaid licensed beds on the Second-floor nursing unit in the following rooms: 224, 225, and 226 totaling 12 beds. During observations of the Second-floor nursing unit on 12/27/24, at 9:28 a.m. the following was observed: -the Second-floor nursing unit found 12 allocated beds not prepared for resident use as follows: -Room 224 indicated four bed frames in disrepair with headboards and foot boards removed and air mattresses on the floor. -Room 225 indicated six headboards and bulletin boards on the floor, air mattress on one bed stained	H 0005		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395666	A. BLDG: __00_____ B. WING: _____	12/27/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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H 0005	Continued from page 2 brown in the center, a cart with side rail and bed parts and a can of interior primer paint, metal mesh like vent on bedside stand, and debris throughout the room. -Room 226 indicated three head and foot boards resting on a bed, one bed frame without a mattress, air mattresses on the floor and a flat screen TV faced down on the bedside stand, a PTAC unit (packaged terminal air conditioner that heats and cools small areas) with the unit's face removed, exposing the inside. During an interview and tour on 12/27/24, at 10:00 a.m. the Nursing Home Administrator (NHA) confirmed the 12 allocated beds were not prepared for resident use and information disseminated to NHA that the facility failed to provide notification to the Department that it had reduced the number of licensed beds.	H 0005		

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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	1. Staffing coordinator will be educated on CNA ratio requirements. 2. A scheduling app has been implemented for direct care staff and staff are acclimating to the procedures of applying for shifts and picking up open shifts/called off shifts. 3. Facility conducts daily labor meetings attended by DON and NHA to manage direct care staff and monitor CNA ratios and track new applicants/new hires. 4. Staffing coordinator/designee to audit daily staffing sheet x 3 weeks to meet CNA ratio requirements. 5. Results reported to QAPI for review and approval.	Completion Date: **02/15/2025** Status: **APPROVED** Date: **01/21/2025**

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

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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P 5520	Continued from page 1 Based on review of staffing documents provided by the facility and staff interview, it was determined that the facility failed to provide one nurse assistant (NA) per 10 residents on the daylight shift on two of seven days (12/22/24, and 12/24/24), one NA per 11 residents on the evening shift on three of seven days (12/22/24, 12/23/24, and 12/26/24) and one NA per 15 residents on the night shift on three of seven days required (12/20/24, 12/21/24, and 12/22/24). Findings include: A review of facility staffing documents provided by the facility from 12/20/24, through 12/26/24, revealed the facility failed to provide NA on the following shifts as required: Daylight shift: Date Census Staff needed Staff present	P 5520		

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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P 5520	Continued from page 2	P 5520		

12/22/24 77 7.7 5.97
12/24/24 75 7.5 5.95

Evening shift:

12/22/24 77 7 6.26
12/23/24 76 6.91
6.2
12/26/24 75 6.82 5.74

Night shift:

12/20/24 77 5.13
2.07
12/21/24 77 5.13
3.99
12/22/24 77 5.13
3.01

Interview on 12/27/24 at 2 p.m., the Nursing Home Administrator confirmed that the facility failed to provide NA's in the facility on the above shifts as

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P 5520	Continued from page 3 required.	P 5520		
P 5530	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	1. Staffing coordinator will be educated on LPN ratio requirements. 2. A scheduling app has been implemented for direct care staff and staff are acclimating to the procedures of applying for shifts and picking up open shifts/called off shifts. 3. Facility conducts daily labor meetings attended by DON and NHA to manage direct care staff and monitor LPN ratios and track new applicants/new hires. 4. Staffing coordinator/designee to audit daily staffing sheet x 3 weeks to meet LPN ratio requirements. 5. Results reported to QAPI for review and approval.	Completion Date: **02/15/2025** Status: **APPROVED** Date: **01/21/2025**

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P 5530	Continued from page 4 Based on review of nursing schedules and staff interview it was determined that the facility administrative staff failed to provide a minimum of one LPN per 40 residents during the night shift one of seven days reviewed. (12/21/24). Findings include: Review of the facility census data and schedules from 12/20/24, through 12/26/24, revealed the following LPN staffing shortage: Night shift: 12/21/24 census 77 Staff needed 1.93 Staff present 1.89 Interview with Nursing Home Administrator on 12/27/24/24, at 2:00 p.m. confirmed facility administrative staff failed to provide a minimum of one LPN per 40 residents during the night shift as required.	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	1. Staffing coordinator to be educated on maintaining a minimum PPD of 3.20 for direct care staff. 2. A scheduling app has been implemented for direct care staff and staff are acclimating to the procedures of applying for shifts and picking up open shifts. 3. Facility to conduct daily labor meetings attended by DON and NHA to manage direct care staff and monitor staffing calculation spreadsheet. 4. NHA/designee to educate DON and licensed nurses to alert NHA/DON to shortages and/or call offs. 5. NHA/designee to audit ratios 1/week for 6 weeks. 6. Results reported to QAPI for review and approval.	Completion Date: **02/15/2025** Status: **APPROVED** Date: **01/21/2025**

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P 5640	Continued from page 6 Based on a review of nursing time schedules and staff interview it was determined that the facility failed to provide a minimum of 3.20 PPD (per patient daily) hours of direct care for each resident for five out of seven days reviewed (12/20/24 - 12/26/24) as required. Findings include: Review of staffing documents and nurse schedules for seven days (12/20/24 - 12/26/24) indicated that required PPD minimum hours of 3.20 was not met on the following days: 12/20/24 - PPD 3.03 12/21/24 - PPD 3.04 12/22/24 - PPD 2.64 12/23/24 - PPD 3.04 12/24/24 - PPD 3.1 Interview on 12/26/24, at 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide a minimum of 3.20 PPD hours of direct care for each resident for five of seven days	P 5640		

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P 5640	Continued from page 7 reviewed as required (12/20/24 - 12/26/24).	P 5640		

Certified End Page

SPRING HILL REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 192902

SURVEY EXIT DATE: 12/27/2024

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

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