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:	04/18/2025

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 a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance, and an Abbreviated survey in response to three complaints completed on April 18, 2025, 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 and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations	F 0000		
F 0569 SS=D		F 0569		

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 0569 SS=D	Continued from page 1 483.10(f)(10)(iv)(v) Notice and Conveyance of Personal Funds §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by:	F 0569	1. The affected former residents will be reimbursed immediately. 2. The Business Office Manager/designee will audit the Resident Trust account statement to ensure other discharged Residents received their refund within 30 days of discharge. 3. Residents who discharge in the future will be refunded their remaining resident trust funds within 30 days of discharge. 4. NHA will educate BOM on the importance of refunding discharge residents the remaining Resident Trust funds within 30 days of discharge. 5. The BOM/designee will audit the Resident Trust statement 1x/week for 4 weeks, then monthly x 2 months. 6. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/14/2025**

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F 0569 SS=D	Continued from page 2 Based on review of facility policy, closed clinical records, resident fund account statements and staff interview it was determined that the facility failed to convey resident funds in accordance with State law and closed accounts upon discharge in a timely manner for one out of two sampled records (Closed Resident Record CR984). Findings include: The facility "Resident personal funds" policy last reviewed 12/9/24, indicated that upon discharge, eviction or death of a resident with a personal fund deposited with the facility, the facility will convey within 30 days the resident's funds and a final account of those funds. Review of Closed Resident Record CR984's admission record indicated he was admitted on 6/28/24. Review of Closed Resident Record CR984's MDS	F 0569		

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F 0569 SS=D	Continued from page 3 assessment (MDS: Minimum Data Set assessment-a periodic assessment of resident care needs) dated 10/8/24, indicated he had diagnoses that included chronic obstructive pulmonary disease (COPD: a disease characterized by persistent respiratory symptoms involving breathlessness, coughing, and obstructed airflow to the lungs), diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), and schizophrenia (a type of mental condition involving a breakdown in the relation between thought, emotion, and behavior leading to a faulty perception inappropriate action and feelings, withdrawal from reality and personal relationships into fantasy and delusion). These diagnoses were the most recent upon review. Review of Closed Resident Record CR984's clinical nurse progress note dated 11/7/24, indicated that he was discharged from facility at 10:00am. in a private vehicle. Medication reviewed with resident along with doctors appointments. Spoke with sister and she stated she would meet him at his new apartment.	F 0569		

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F 0569 SS=D	Continued from page 4 Review of facility trust fund account (account with current account open with facility resident funds) dated 4/17/25, indicated that Closed Resident Record CR984 still had an open account with a balance of $41.02. During an interview on 4/17/25, at 11:39 a.m. the Regional Business Office Manager Employee E30 confirmed that the facility failed to convey resident funds in accordance with State law and closed accounts upon discharge for Closed Resident Record CR984 as required. 28 Pa. Code 211.5(d) Clinical records.	F 0569		
F 0584 SS=E		F 0584		

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F 0584 SS=E	Continued from page 5 483.10(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. Facility immediately cleaned ice machine in clean utility room, fixed soap dispensers in resident bathrooms, and emptied trash cans and cleaned shower rooms. 2. NHA/designee will educate Plant Ops manager on clean, homelike environment and correct par levels for facility. 3. Linen and bedding/blankets were purchased and dispersed into cycle. 4. NHA/designee will monitor linen supply for appropriate par levels. 5. Plant Operations Manager to audit clean, homelike environment within facility and linen supply 3x/week for 3 weeks, then 1x/week for 3 weeks. 6. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/16/2025**

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F 0584 SS=E	Continued from page 6 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 7 Based on facility policy review, observations, resident council group interview, resident and staff interviews, it was determined that the facility failed to maintain a safe, clean, and home-like environment for one of two shower rooms (One-West), one clean utility room (One-East) and four out of five resident rooms (Resident R22, R46, R61, and Resident R63) and the facility failed to maintain an adequate supply the following day of wash clothes, towels, and blankets readily available for two of two nursing units. . Findings include: The facility "Safe and homelike environment" policy reviewed 12/9/24, indicated that the facility will provide a safe, clean, comfortable and homelike environment. During a tour on 4/15/25, at 9:30 a.m. the following was observed in the clean utility room on One-East with the Director of Maintenance/ Housekeeping Employee E13:	F 0584		

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F 0584 SS=E	Continued from page 8 - the ice machine water outlet was observed with brown substance on water outlet. PC-piping behind the ice machine was found with black spotted substance on PC-piping leading to the drain. During an interview on 4/15/25, at 9:31 a.m. the Director of Maintenance/ Housekeeping Employee E13 stated: "tubing been here since I've been working here" and confirmed the facility failed to maintain a clean, homelike environment in the clean utility room. During an interview on 4/15/25, at 11:00 a.m. three of six residents stated the their bathroom soap dispensers were broken. During observations on 4/16/25, the following was observed: at 9:50 a.m. Resident R61 bathroom was observed with a broken soap dispenser. at 9:51 a.m. Resident R22 bathroom was observed with a broken soap dispenser. at 9:52 a.m. Resident R46 was found with long	F 0584		

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F 0584 SS=E	Continued from page 9 brown stain on bedside curtain. at 9:56 a.m. Resident R63 bathroom was observed with a broken soap dispenser. During an interview on 4/16/25, at 10:01 a.m. the Director of Maintenance/ Housekeeping Employee E13 confirmed that the facility failed to the facility failed to maintain a safe, clean, and home-like environment for Residents R22, R46, R61, and Resident R63. During observations on 4/17/25, the following was observed: at 10:04 a.m Resident R278 was heard yelling in hall "someone please clean the shower room. I can't even take a shower." at 10:06 a.m. the One-West shower room was found with brown substance in small trash can. A horrendous odor was emitting from the trash can and the bathroom. No staff were found cleaning the area.	F 0584		

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F 0584 SS=E	Continued from page 10 During an interview on 4/17/25, at 1:34 p.m. information was disseminated to the Nursing Home Administrator (NHA) that the facility failed to maintain a safe, clean, and home-like environment as required. Observations on the first and second nursing units linen carts revealed the following: 04/15/25 10:10 AM observation of clean linen - 3 gowns, 7 flat sheet s, 5 fitted, 3 blankets. 2nd floor -04/15/25 10:12 AM low side of 2nd floor - approx 10 gowns, 7 flat sheets, 5 fitted, 6 pillow cases, 4 blankets - Hoyer lift. 4/16/25 11:39 a.m. on first floor nursing unit - 14 gowns. 04/16/25 11:43 AM on 2nd floor - 11 gowns /4 loose sheets/ 3 fitted sheets sweet shirt and pajama bottoms / 1 heavy blanket / 1 pad /1 tennis shoes.	F 0584		

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F 0584 SS=E	Continued from page 11 04/16/25 11:47 AM 15 gowns/ 10 loose sheets/ 6 blankets heavy/ 5 fitted/ 2 Hoyer lift / 2 pads. On both days of observations - no wash clothes or towels were observed on the linen carts, and limited heavy blankets were found on linen carts during observations. During observations in Director of Maintenance Employee E13 confirmed that the facility did not have enough linen supplies of wash clothes, towels, and heavy blankets. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management	F 0584		

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F 0584 SS=E	Continued from page 12	F 0584		
F 0610 SS=D	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	1. Facility will attempt to obtain witness statements for events related to R23 and R24, and events will be reported in ERS. 2. DON/designee will complete a 6 month look back for other incidents to rule out abuse/neglect and report as needed. 3. DON/designee to educate nursing staff on abuse/neglect and requirements of a thorough investigation. 4. The DON/Designee will audit all Incident Reports to ensure a thorough investigation weekly x 2 weeks, then 5 incident reports per week x 3 weeks. 5. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/20/2025**

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F 0610 SS=D	Continued from page 13 Based on review of facility policy, review of facility provided documents, clinical records, and staff interview, it was determined that the facility failed to thoroughly investigate to rule out potential neglect for two of four residents (Resident R23 and R24). Findings include: Review of facility policy "Abuse, Neglect, Mistreatment Education" last reviewed 12/9/24, indicated that the facility prohibits the mistreatment and neglect of residents. The facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident neglect and mistreatment. Neglect is the failure to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress. The Administrator and Director of Nursing are responsible for investigating and reporting incidents of neglect. Upon receiving an incident or suspected incident of abuse or neglect, the Administrator/DON/designees will conduct an investigation to include interviews of any witnesses,	F 0610		

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F 0610 SS=D	Continued from page 14 the resident, the attending physician, and staff members (on all shifts) having contact with the resident during the period of the alleged incident. Review of the clinical record revealed that Resident R23 was admitted to the facility on 3/4/24, and readmitted 10/3/24. Review of Resident R23's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/21/25, indicated diagnoses of high blood pressure, peripheral vascular disease, and diabetes. Review of Resident R23's physician order dated 4/12/25, indicated to cleanse the vascular wound on the left shin with normal saline, pat dry, apply collagen (used to stimulate new tissue growth), calcium alginate highly absorbent dressings ideal for wounds with moderate to heavy exudate) to wound bed, cover with gauze island dressing daily and as needed. May cover with abdominal pad (pas that absorb fluid and create a moisture barrier for wounds) and wrap with kerlix (gauze bandage roll)	F 0610		

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F 0610 SS=D	Continued from page 15 if island dressing will not stick, every day shift for peripheral vascular disease. Review of Resident R23's April 2025 Treatment Administration Record (TAR) revealed Resident R23's left shin wound was changed as ordered on 4/13/25, 4/14/25, and 4/15/25. During an observation on 4/15/25, at 11:40 a.m. Resident R23 left lower leg wound dressing was dated 4/12/25. Resident R23 indicated staff were notified it needed to be changed. During an interview on 4/15/25, at 11:41 a.m. LPN, Employee E6 confirmed Resident R23's left lower leg wound dressing was not changed as ordered and dated 4/12/25. During an interview on 4/15/25, at 11:47 a.m. the Nursing Home Administrator (NHA) confirmed the facility failed to change Resident R23's wound dressing as ordered. The NHA indicated an investigation will be completed.	F 0610		

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	395666	A. BLDG: __00_____ B. WING: _____	04/18/2025

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F 0610 SS=D	Continued from page 16 Review of Resident R23's neglect investigation on 4/17/25, at 9:39 a.m. failed to include witness statements from staff who signed of the resident's dressing change was completed as ordered on 4/13/25, 4/14/25, and 4/15/25. Review of the clinical record revealed that Resident R24 was admitted to the facility 2/21/25. Review of Resident 24's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/4/25, indicated diagnoses sepsis (condition that occurs when the body's immune system has an extreme response to an infection, leading to inflammation that can damage its own tissues and organs), hydrocephalus (buildup of fluid in the brain ventricles that can damage brain tissue and cause various symptoms), and seizures. Review of clinical record progress note dated 3/15/25, at 3:46 a.m., revealed a Nurse Aide (NA) reported to nurse that Resident R24 was crawling	F 0610		

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F 0610 SS=D	Continued from page 17 around on the floor in a puddle of blood behind roommates bed. Assessment found an open cut above right eye that is heavily bleeding. Unsure what resident hit her head on. Resident R24 sent to the hospital, message left for daughter, physician notified. Review of facility submitted documents dated 3/17/25, indicated that a NA reported to unit nurse that Resident R24 was crawling around floor in a puddle of blood behind roommate's bed. Resident R24 was assessed and had an open cut above right eye that was heavily bleeding. First aid was provided. Call placed to 911, resident being sent to hospital for evaluation. Review of facility provided investigation on 4/17/25, at 8:30 a.m., failed to include signed and dated witness statements from the resident's roommate and/or all staff members who had contact with the resident during the shift incident occurred. During an interview on 4/17/25, at 9:44 a.m., the	F 0610		

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F 0610 SS=D	Continued from page 18 Director of Nursing (DON) confirmed that Resident R24's incident investigation failed to include witness statements to rule out potential neglect. During an interview on 4/17/25, at 3:17 p.m., the Nursing Home Administrator (NHA) confirmed the facility failed to thoroughly investigate potential neglect for two of four residents (Resident R23 and R24). 28 Pa. Code: 201.14(c)(d)(e) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(2)(e)(1) Management. 28 Pa. Code: 201.19 Personnel policies and procedures. 28 Pa. Code: 201.20(a)(b)(c)(d) Staff development. 28 Pa. Code: 201.29(a)(c)(d)(j)(m) Resident rights.	F 0610		

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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 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	F 0620	1. A whole house audit was completed on admission documents and providing a comprehensive review of resident admission rights, policies, and payment requirements. 2. Future Residents will not be charged a $1000 monthly fee while awaiting Medicaid approval. 3. NHA/designee to educate Business Office Manager on the need to cease charging Medicaid pending residents the $1000 fee while waiting to be approved for Medicaid. 4. BOM/designee to audit resident statements monthly x3 months to ensure the issue does not recur. 5. NHA/designee to educate Social Services on the need to complete Admissions documents and providing a comprehensive review of resident admission rights, policies, and payment requirements. 6. Social Services/designee to audit admissions documents and resident admission rights, policies, and payment requirements 2x/week for 2 weeks, then monthly x 2 months. 7. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/16/2025**

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F 0620 SS=D	Continued from page 20 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. §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	F 0620		

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F 0620 SS=D	Continued from page 21 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 22 Based on review of facility policy, resident records, admissions documentation, billing documents, resident and staff interviews it was determined that the facility failed to maintain admission documentation for two of four sampled residents (Resident R32 and Resident R57) and failed to provide a comprehensive review of resident admission rights, policies, and payment requirements for two of four residents (Resident R62 and R66). Findings include: The facility "Resident rights" policy reviewed 12/9/24, indicated that the facility will inform the resident both orally and in writing of his or her rights and regulations governing resident conduct and responsibilities during the stay in the facility. Review of Resident R32's admission record indicated she was admitted on 3/31/25. Review of Resident R32's MDS assessment (MDS: Minimum Data Set assessment-a periodic	F 0620		

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F 0620 SS=D	Continued from page 23 assessment of resident care needs) dated 4/6/25, indicated she had diagnoses that included diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), muscle weakness and depression (a state of sadness and loss of interest interfering in daily life activities). Section C0200 BIMS (Brief interview for mental status) revealed that Resident R32 s BIMS score of "12" which indicated that she was cognitively intact. Review of Resident R32's nurse admission assessment dated 3/31/25, indicated she was fully alert and oriented. Review of Resident R32's clinical record did not include her admissions records. Review of Resident R57's admission record indicated he was admitted on 3/28/25. Review of Resident R57's MDS assessment dated 4/3/25, indicted that he had diagnoses that included heart failure, diabetes, and hyperlipidemia (elevated	F 0620		

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F 0620 SS=D	Continued from page 24 lipid levels within the blood). These diagnoses were the most recent upon review. Review of Resident R57's clinical notes indicated that family was involved with his care. Review of Resident R57's clinical record did not include signed admissions records. Further review of Resident R32 and Resident R57's documentation did not include an admissions packet or discussion upon admission that included patient portion liability, the daily rate cost structure, resident rights, representative/resident appeal rights, consent to receive treatment, Medicare process, Medicaid process, right to choose ancillary services, bed hold policy, and the consequences for failure to pay. Review of Resident R62's admission record indicated he was originally admitted 10/30/24. Review of Resident R62's MDS assessment dated 3/25/25, indicated he had diagnoses that included	F 0620		

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F 0620 SS=D	Continued from page 25 schizophrenia (a type of mental condition involving a breakdown in the relation between thought, emotion, and behavior leading to a faulty perception inappropriate action and feelings, withdrawal from reality and personal relationships into fantasy and delusion), general weakness and abnormal gait. Review of Resident R66's admission record indicated he was originally admitted on 7/26/24. Review of Resident R66's MDS assessment dated 3/5/25, indicated he had diagnoses that included diabetes, peripheral vascular disease (a progressive narrowing of the blood vessels impacting blood flow to the limbs), and hypertension (a condition impacting blood circulation through the heart related to poor pressure). Review of the facility admissions packet information (documents completed upon admission) did not include per diem cost for resident stay, Medicaid pending portion payment information, or a description of fees for services.	F 0620		

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F 0620 SS=D	Continued from page 26 Review of facility billing documents indicated that Resident R62 had a Medicaid pending portion bill for $2000, and Resident R66 had a bill for Medicaid pending portion of $5000. During an interview on 4/16/25, at 11:05 a.m. the Regional Business Office Manager Employee E30 stated: "If a residents comes in Medicaid pending or they are an insurance cut and apply for Medicaid, our office will try to find out their income. If family is doing it, they might not know the income. We have a default amount we bill at $1000 per month known as the Medicaid pending pay rate. The facility billing company determined the rate. Families may get the bill for $1000, but for some people that is over. We let them know that we look at income, and resident may get $60. If the family or resident happen to know the income, and we found out that amount and the bill is not adjusted and the facility is paid the difference. We have an Medicaid estimate paper. Medicaid pending rate is not in the admissions packet. Its has been like that since the facility was	F 0620		

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F 0620 SS=D	Continued from page 27 bought. The facility can credit the bill and adjust it and we only use the resident's money to bill. We do not ask the family to use their money to pay the bill. It is not written anywhere. We do this at all four of our facilities." During an interview on 4/17/25, at 9:02 a.m. Resident R66 stated the following: "I've been here since July 2024. I was involved in a car accident, went to the hospital and had surgery. I do not know anything about a Medicaid pending bill. I didn't receive any bills. I'm on a Medicaid insurance plan. They did not review any payment responsibility or payment/bill schedule with me." During an interview on 4/17/25, at 9:16 a.m. Resident R62 stated the following: "I was admitted around September 2024. My family and wife visit me. My insurance pays for my stay. I have not gotten any bills while I was here. I think I signed admissions paper work but no one reviewed what I had to pay."	F 0620		

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F 0620 SS=D	Continued from page 28 During an interview on 4/17/25, at 10:29 a.m. the facility Admissions Coordinator Employee E9 she does not reviews admission packet with resident as she works from home and does the insurance. She stated she was the only admissions staff. She stated she did not know what Medicaid pending portion bill was and she hands that off to the financial department. If the resident is Medicaid pending, she reaches out to the financial department and they run a financial screen and we go from there for the approval. She stated she has not seen the admissions packet and that the Nursing Home Administrator should be asked about reviewing admissions with residents. During an interview on 4/17/25, at 10:59 a.m. the Registered Nurse (RN) Employee E10 confirmed that the facility failed to provide a comprehensive review of resident admission rights and maintain admission documentation for Resident R32 and Resident R57 as required. During an interview on 4/17/25, at 1:34 p.m.	F 0620		

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F 0620 SS=D	Continued from page 29 information disseminated to the Nursing Home Administrator (NHA) facility the facility failed to maintain admission documentation for two of two sampled residents (Resident R32 and Resident R57) and failed to provide a comprehensive review of resident admission rights, policies, and payment requirements for two of two residents (Resident R62 and R66) as required. 28 Pa Code: 201.18 (b)(2) Management. 28 Pa Code: 201.24 (a) Admission policy. 28 Pa Code: 201.19 (i) Resident rights.	F 0620		
F 0622 SS=D		F 0622		

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F 0622 SS=D	Continued from page 30 483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident	F 0622	1. The facility is unable to go back and make certain that specific information was communicated to the receiving health care provider during resident transfers. 2. DON/designee to educate licensed staff on comprehensive transfer protocol regarding providing specific information to receiving health care provider and appropriate documentation on the event. 3. DON/designee to audit hospital transfers to ensure proper documentation is sent 5x/week for 2 weeks, then 3x/week for 2 weeks, and 1x/week for 2 weeks. 4. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/20/2025**

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: _____	04/18/2025

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

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F 0622 SS=D	Continued from page 31 while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i) (A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and	F 0622		

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 0622 SS=D	Continued from page 32 (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by:	F 0622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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STATE LICENSE NUMBER: **192902**	

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F 0622 SS=D	Continued from page 33 Based on review of facility policies, resident records and staff interview, the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two out of three residents sampled with facility-initiated transfers (Resident R47 and R76). Finding include: Review of Resident R47's clinical record indicated the resident was admitted to the facility on 6/27/24, and readmitted on 3/20/25, with diagnoses of intellectual disabilities, dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident R47's progress note dated 3/17/25, indicated the resident was heard making grunting noises from his room at 3:25 a.m. The resident was sitting upright at his bedside pointing to	F 0622		

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 0622 SS=D	Continued from page 34 his chest and throat, unable to speak. The resident's blood pressure was elevated, had a right sided facial droop, left arm weakness, fatigues, unstable gait, and light headedness. The nurse called 911 and the resident was transferred out to the hospital. Review of Resident R47's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R47's progress note dated 3/17/25, at 11:01 a.m. revealed staff received a call from the hospital treating the resident and inquired about the resident's baseline. Review of the clinical record indicated Resident R76 was admitted to the facility on 11/1/24.	F 0622		

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 0622 SS=D	Continued from page 35 Review of Resident R76's MDS dated 11/7/24, indicated diagnoses of high blood pressure, depression, and dementia. Review of Resident R76's clinical record revealed that the resident was transferred to the hospital on 1/16/25 and did not return to the facility. Review of Resident R76's progress note dated 1/16/25, at 7:07p.m. revealed the resident continued to have elevated blood pressure and now complaining of a headache. It was indicated the on call provider was called again, and ordered the resident to be transferred to the hospital. Review of Resident R76's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident	F 0622		

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 0622 SS=D	Continued from page 36 representative information, and all information necessary to meet the resident's specific needs at the receiving facility. During an interview on 4/17/25, at 11:07 a.m. the Nursing Home Administrator confirmed that there was no evidence that the necessary information was communicated to the receiving health care institution or provider upon transfer for two out of three residents sampled with facility-initiated transfers (Residents R47 and R76). 28 Pa. Code 201.29 (a)(c.3)(2) Resident rights.	F 0622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0623 SS=D	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)	F 0623	1. Facility will generate a form to be sent with the previous hospitalizations/discharges document that was being sent to the Office of Long-Term Care Ombudsman for hospitalizations and discharges. 2. NHA/designee to educate Director of Social Services on appropriate notification to be sent to the Office of Long-Term Care Ombudsman for hospitalizations and discharges. 3. NHA/designee to audit documents sent to the Office of Long-Term Care Ombudsman for hospitalizations and discharges 1x/week for 3 weeks and monthly x 3 months. 4. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/16/2025**

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 0623 SS=D	Continued from page 38 (A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the	F 0623		

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F 0623 SS=D	Continued from page 39 protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by:	F 0623		

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F 0623 SS=D	Continued from page 40 Based on review of resident clinical records, and staff interviews, it was determined that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for two of two residents (Resident R47, and R76). Findings Include: Review of Resident R47's clinical record indicated the resident was admitted to the facility on 6/27/24, and readmitted on 3/20/25, with diagnoses of intellectual disabilities, dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident R47's clinical record revealed that the resident was transferred to the hospital on 3/17/25, and returned to the facility on 3/20/25.	F 0623		

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F 0623 SS=D	Continued from page 41 A review of Resident R47's clinical record indicated the facility failed to include documented evidence that the facility provided a copy of the written notice that includes the reason for the transfer to the Office of Long-Term Care Ombudsman for the hospitalization on 3/17/25. Review of Resident R76's clinical record indicated the resident was admitted to the facility on 11/1/24, with diagnoses of high blood pressure, depression, and dementia. Review of Resident R76's clinical record revealed that the resident was transferred to the hospital on 1/16/25 and did not return to the facility. A review of Resident R76's clinical record indicated the facility failed to include documented evidence that the facility provided a copy of the written notice that includes the reason for the transfer to the Office of Long-Term Care Ombudsman for the hospitalization on 1/16/25.	F 0623		

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F 0623 SS=D	Continued from page 42 During an interview on 4/17/25, at 11:07 a.m. information disseminated to the Nursing Home Administrator, regarding the notice to a representative of the Office of the Long-Term Care Ombudsman Division was not provided for two of two residents (Resident R47 and R76). 28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.	F 0623		
F 0625 SS=D		F 0625		

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 0625 SS=D	Continued from page 43 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 0625	1. Facility is unable to go back and make certain that all hospital transfers were provided with written information on the facility's bed hold policy at the time of transfer. 2. Moving forward residents will be provided with the bed hold policy at the time of transfer to the hospital/therapeutic leave of absence. 3. DON/designee to educate nursing staff on the need to provide residents with the bed hold policy and bed hold/transfer documents at the time of transfer to the hospital or therapeutic leave of absence and to document in EHR that bed hold policy was provided. 4. IDT will audit the medical record during daily stand up meeting to ensure the transfer note includes reference to the bed hold policy being issued to the resident prior to discharge. 5. DON/designee to audit transfer notes and bed hold policies 1x/week for 4 weeks. 6. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0625 SS=D	Continued from page 44	F 0625		

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F 0625 SS=D	Continued from page 45 Based on review of resident clinical records, and staff interviews, it was determined that the facility failed to provide evidence that a written notification of the facility bed hold policy was provided to the resident upon transfer to the hospital for two of two residents (Resident R47 and R76). Findings Include: Review of Resident R47's clinical record indicated the resident was admitted to the facility on 6/27/24, and readmitted on 3/20/25, with diagnoses of intellectual disabilities, dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident R47's clinical record revealed that the resident was transferred to the hospital on 3/17/25, and returned to the facility on 3/20/25.	F 0625		

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: _____	04/18/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SPRING HILL REHABILITATION AND NURSING CENTER	**2170 RHINE STREET PITTSBURGH, PA 15212**
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F 0625 SS=D	Continued from page 46 A review of Resident R47's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 3/17/25. Review of Resident R76's clinical record indicated the resident was admitted to the facility on 11/1/24, with diagnoses of high blood pressure, depression, and dementia. Review of Resident R76's clinical record revealed that the resident was transferred to the hospital on 1/16/25 and did not return to the facility. A review of Resident R76's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 1/16/25. During an interview on 4/17/25, at 11:07 a.m. the Nursing Home Administrator confirmed that there	F 0625		

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F 0625 SS=D	Continued from page 47 was no evidence that a written notification of the facility bed hold policy was provided to the resident upon transfer to the hospital for two of two residents (Resident R47 and R76). 28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.	F 0625		
F 0676 SS=D		F 0676		

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 0676 SS=D	Continued from page 48 483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting,	F 0676	1. Resident R177 did not experience any adverse effects, care plan updated and resident is satisfied. 2. The facility will utilize Language Line in order to effectively communicate with foreign language speaking residents. 3. NHA/designee to educate all staff on the usage of Language Line to effectively communicate to foreign language speaking residents. 4. NHA/designee to audit effective communication with foreign speaking residents and utilization of language line 5x/week for 2 weeks, then 2x/week for 2 weeks. 5. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/20/2025**

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 0676 SS=D	Continued from page 49 §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by:	F 0676		

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F 0676 SS=D	Continued from page 50 Based on review of facility policy, clinical record review, observations and staff interviews, it was determined that the facility failed to provide language assistance services to maintain activities of daily living (ADLs) for communication for one of two residents (Resident R177). Findings include: The facility "Language assistance services" policy reviewed 12/9/24, indicated that the facility will take responsible steps to ensure that individuals with limited English proficiency have access to language assistance services and meaningful communication involving their medical treatment. Review of Resident R177's admission record indicated she was admitted on 3/28/25. Review of Resident R177's initial nurse assessment dated 3/28/25, indicated she had diagnoses that included hypotension (low blood pressure), wound of the left heel and cellulitis (bacterial infection of the	F 0676		

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F 0676 SS=D	Continued from page 51 skin causing redness, aches, and swelling) of both lower extremities. The assessment identified Resident R177 primary language as French. Review of Resident R177's care plan dated 3/28/25, indicated a language barrier. Review of Resident R177's clinical nurse progress note dated 4/8/25, indicated she only speaks French. During observations on 4/14/25, at 10:17 a.m. Resident R177 was observed in her room and only speaking French. During an interview on 4/15/25, at 9:54 a.m. Licensed Practical Nurse (LPN) Employee E6 stated: "Nurse Aide (Na) Employee E7 is assigned to Resident R177. She has an application on her phone to communicate and she should know how to use it. We were told to get the app on our phone and that is how we communicate."	F 0676		

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F 0676 SS=D	Continued from page 52 During an interview on 4/15/25, at 9:56 a.m. Nurse Aide (NA) Employee E7 stated: "I do not have an app on my phone. Resident R177 usually points to what she wants. This is my first time having her. She does not have a communication board." During an observations and interview on 4/15/25, at 10:00 a.m. an interview was attempted with Resident R177. Nurse aide (NA) Employee E8 present trying to use electronic phone application. Nurse aide (NA) Employee E8 stated: " I have a translator app." All attempts to communicate with Resident R177 did not succeed. During an interview on 4/15/25, at 2:39 p.m. information disseminated to the Nursing Home Administrator (NHA) that the facility failed that the facility failed to provide language assistance services to maintain activities of daily living (ADLs) for communication for Resident R177 as required. 28 Pa. Code: 211.12(d)(5) Nursing services.	F 0676		

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F 0676 SS=D	Continued from page 53	F 0676		
F 0684 SS=E		F 0684		

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F 0684 SS=E	Continued from page 54 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1. The facility is unable to go back and make certain physician orders were followed and a resident received treatment and care in accordance with professional standards of practice. 2. DON completed a whole house wound investigation and found no other residents with dressings not changed per physician order and that the identified wounds with outdated dressings were not worsening. 3. DON/designee will complete a 30-day lookback of all current physician's orders to ensure they have been signed off. 4. DON/designee to educate licensed staff on following treatment orders/physicians orders including pharmacy ordering and first dose machine, readmission orders, notifying physicians timely with change in conditions. 5. DON to audit physician's orders including readmission orders and timely notification of change in conditions, and medication availability via pharmacy delivery or	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/20/2025**

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F 0684 SS=E	Continued from page 55	F 0684	first dose system 5x/week for 2 weeks, then 3x/week for 2 weeks, and 1x/week for 2 weeks. 6. Results to be submitted to QAPI for review and approval.	

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 0684 SS=E	Continued from page 56 Based on observations and resident and staff interviews, it was it was determined that the facility failed to make certain that residents were provided appropriate treatment and care for three of four residents (Resident R16, R23, R52 and R128). Findings include: Review of the clinical record revealed that Resident R16 was admitted to the facility on 1/2/25. Review of Resident R16's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 1/7/25, indicated diagnoses of right below the knee amputation, diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces) , and peripheral vascular disease (a slow and progressive disease that impacts the blood vessels in the body outside the heart.) Review of Resident R16's active physician order	F 0684		

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F 0684 SS=E	Continued from page 57 dated 3/17/25, indicated to cleanse Resident R16's diabetic left plantar foot ulcer with normal saline solution (wound cleanser), pat dry, apply Mupirocin ointment (topical antibiotic for bacterial skin infections), and cover with a bordered dressing daily. During an observation on 4/14/25, at 2:05 p.m. Resident R16's left plantar foot wound dressing was dated 4/12/15. During an interview on 4/14/25, at 2:16 p.m. Licensed Practical Nurse, Employee E6 confirmed Resident R16's wound dressing was ordered daily and was dated 4/12/25. During an interview on 4/14/25, at 3:14 p.m. the Director of Nursing confirmed the facility failed to change Resident R16's wound dressing as ordered. Review of the clinical record revealed that Resident R23 was admitted to the facility on 3/4/24, and readmitted 10/3/24.	F 0684		

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F 0684 SS=E	Continued from page 58 Review of Resident R23's MDS dated 1/21/25, indicated diagnoses of high blood pressure, peripheral vascular disease, and diabetes. Review of Resident R23's physician order dated 4/12/25, indicated to cleanse the vascular wound on the left shin with normal saline, pat dry, apply collagen (used to stimulate new tissue growth), calcium alginate highly absorbent dressings ideal for wounds with moderate to heavy exudate) to wound bed, cover with gauze island dressing daily and as needed. May cover with abdominal pad (pas that absorb fluid and create a moisture barrier for wounds) and wrap with kerlix (gauze bandage roll) if island dressing will not stick, every day shift for peripheral vascular disease. Review of Resident R23's April 2025 Treatment Administration Record (TAR) revealed Resident R23's left shin wound was changed as ordered on 4/13/25, 4/14/25, and 4/15/25.	F 0684		

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F 0684 SS=E	Continued from page 59 During an observation on 4/15/25, at 11:40 a.m. Resident R23 left lower leg wound dressing was dated 4/12/25. Resident R23 indicated staff were asked to change the dressing and no one has. During an interview on 4/15/25, at 11:41 a.m. LPN, Employee E6 confirmed Resident R23's left lower leg wound dressing was not changed as ordered and dated 4/12/25. During an interview on 4/15/25, at 11:47 a.m. the Nursing Home Administrator (NHA) confirmed the facility failed to change Resident R23's wound dressing as ordered. During an interview on 4/16/25, at 11:11 a.m. Registered Nurse, Employee E10 stated if a resident's wound treatment was not completed, the next shift would be notified. RN, Employee E10 stated the order would not be signed off in the clinical record until it was completed. During an interview on 4/17/25, at 9:41 a.m. the	F 0684		

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F 0684 SS=E	Continued from page 60 DON confirmed the facility failed to provide necessary treatment as ordered for two of two residents (Resident R16 and R23.) Review of Resident R52's admission record indicated he was admitted to the facility on 9/10/24, and readmitted on 2/20/25. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 2/4/25, included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), high blood pressure, and stage 4 chronic kidney disease (severe kidney function loss and high risk of complications and kidney failure). Review of Resident R52's physician order dated 2/2/25, indicated to administer 200 mg Cefpodoxime (antibiotic that treats bacterial infections), one tablet, by mouth twice daily related to stage 4 chronic kidney disease for 10 days. The order was created and confirmed by Registered Nurse, Employee E10. A further reviewed failed to	F 0684		

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F 0684 SS=E	Continued from page 61 indicate a physician signed off on the order. Review of Resident R52's February 2025 Treatment Administration Record revealed the resident received Cefpodoxime from 2/2/25, through 2/13/25. Review of Resident R52's clinical record revealed CRNP, Employee E20 evaluated Resident R52 on 2/12/25, for acute gastrointestinal pain. The resident had localized right and central region pain worse with palpitation that began that morning. The resident did not eat breakfast, had acute diarrhea, and was bloated. CRNP, Employee E52 indicated the resident's antibiotics may be contributing to the abdominal pain and the resident will remain on the antibiotics until 2/14/25. An abdominal x-ray and probiotics were ordered. Review of Resident R52's physician order dated 2/12/25, indicated to obtain an abdominal x-ray for left lower quadrant and central gastrointestinal pain, bloating, and diarrhea.	F 0684		

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(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 0684 SS=E	Continued from page 62 Review of Resident R52's physician order dated 2/12/25, indicated to administer one capsule of 250 mg saccharomyces boulardii (probiotic yeast that can help support the digestive system), for probiotic for 14 days. Review of Resident R52's clinical record revealed CRNP, Employee E20 evaluated Resident R52 on 2/13/25, for acute gastrointestinal pain. It was documented the antibiotics may be a possible contribution and the resident will remain on the antibiotics until 2/14/25. The resident was receptive to trial IV fluids and Mylanta. "Supportive care, possible viral cause." Review of Resident R52's progress note dated 2/13/25, indicated the resident called 911 5-6 times this evening requesting transport to the hospital for complaint of abdominal pain. The x-ray results from 2/12/25 we normal. There was no evidence a physician was notified.	F 0684		

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	395666	A. BLDG: 00 B. WING:	04/18/2025

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F 0684 SS=E	Continued from page 63 Review of Resident R52's progress note dated 2/14/25, at 1:17 a.m. revealed the 911 operator called stating Resident R52 called them to go to the emergency room. RN Supervisor, Employee E24 went to see the resident and Resident R52 complained of severe back and kidney pain with severe diarrhea. "Crying to go to hospital." There was no evidence a physician was notified. Review of Resident R52's progress note dated 2/14/25, at 2:38 a.m. revealed the resident was transferred to the hospital. Review of Resident R52's progress note dated 2/14/25, at 3:00 a.m. indicated the emergency room nurse called concerned about the resident receiving Cefpodoxime. It was confirmed the resident received Cefpodoxime from 2/2/25, until 2/13/25. Review of Resident R52's progress note dated 2/14/25, at 8:31 a.m. revealed the resident was admitted to the hospital with diagnoses of pyelonephritis (kidney infection).	F 0684		

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F 0684 SS=E	Continued from page 64 During an interview on 4/18/25, at 8:59 a.m. the NHA confirmed the facility failed to ensure Resident R52's Cefpodoxime was signed off by a physician prior to administering, and timely provide care and necessary treatment and services for Resident R52 during a change in condition. During an interview on 4/18/25, at approximately 2:10 p.m. the Director of Nursing and Nursing Home Administrator confirmed the facility failed to make certain that residents were provided appropriate treatment and care for three of four residents (Resident R16, R23, and R52). Review of the clinical record indicated that Resident R128 was admitted on 1/18/25. Review of Resident R128 MDS indicated a diagnosis of depression (a common and serious mental disorder that negatively affects how you feel, think, act, and perceive the world), hypokalemia (potassium blood level low), and seizure disorder (a	F 0684		

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F 0684 SS=E	Continued from page 65 brain condition that causes recurring seizures). Review of Resident R128 clinical record progress notes indicated the following changes in condition: 2/17/25 Dietary: "Note Text : F/u for chewing difficulties. NSG reporting she is still having difficulties with minced texture, suggesting change to purees for improved tolerance/intake. Discussed plan with resident." Will also increase mighty shakes to twice a day (BID) due to ongoing poor intake. Plan: regular diet/puree texture, mighty shakes BID. Will continue to monitor intake/wt trends. 2/17/25 Nursing "Regular diet texture. Loss of liquids or solids from mouth when eating or drinking. Holding food in mouth / cheeks or residual food in mouth after meals. Mood appears depressed, sad, tired/has little energy, sluggish, speaking slowly. Abdomen soft with bowel sounds active/normal for resident" 2/17/25 Nursing "Mechanically altered diet. Holding food in mouth / cheeks or residual food in mouth	F 0684		

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F 0684 SS=E	Continued from page 66 after meals." 2/18/25 Nursing " Regular diet texture. Loss of liquids or solids from mouth when eating or drinking. Holding food in mouth / cheeks or residual food in mouth after meals. Mood appears poor appetite, speaking slowly." 2/18/25 Nursing "Resident is not swallowing medications, she is letting medications run out of her mouth, repeated queuing for resident to swallow." 2/19/25 Nursing "Resident pocketed medications, continues not swallow, let medications run out of her mouth." 2/19/25 Nursing "Appears lethargic.Oriented to person. Skin warm, dry, normal for age and race, wounds with the following treatment: Preventative skin measures in place. Regular diet texture. Loss of liquids or solids from mouth when eating or drinking. Holding food in mouth/cheeks or residual food in mouth after meals. Mood appears tired/has little	F 0684		

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F 0684 SS=E	Continued from page 67 energy, poor appetite, speaking slowly." 2/20/25 Nursing "Nurse called RN to assess resident for change in condition. Resident was lethargic and would not open her eyes. Vitals BP 59/40 Pulse 46 Resp 14 02 73% temp 97.1. Took BP on other arm 120/70. Applied o2 5 liters, resident 02 went up to 78%. Applied non rebreather mask with 10 liters 02. 02 Sat went up to 85%. Resident became more alert and opened her eyes and began moaning." Called provider and EMS. PCMA approved resident to be sent to hospital. When EMS arrived, was unable to get BP from arms and got pressure from left leg BP 190/100 and pulse 46. Resident started having tremors. Resident was transferred to UPMC Mercy per family request. Review of clinical record Blood Pressure Summary indicated resident R128 blood pressure was out of range from 2/17/25 to 2/20/25 eight out of nine times with the following:	F 0684		

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F 0684 SS=E	Continued from page 68 2/17/2025 21:26 147/97 mmHg (Lying l/arm) Diastolic High of 89 exceeded Systolic High of 139 exceeded 2/18/2025 21:15 165/90 mmHg (Sitting l/arm) Diastolic High of 89 exceeded Systolic High of 139 exceeded 2/19/2025 00:07 158/88 mmHg (Lying r/arm) Systolic High of 139 exceeded 2/19/2025 11:34 140/84 mmHg (Lying r/arm) Systolic High of 139 exceeded 02/19/2025 11:47 140/84 mmHg (Lying r/arm) Systolic High of 139 exceeded 02/19/2025 16:38 138/96 mmHg (Sitting l/arm) Diastolic High of 89 exceeded 02/19/2025 21:23 119/100 mmHg (Lying l/arm)	F 0684		

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F 0684 SS=E	Continued from page 69 Diastolic High of 89 exceeded 02/20/2025 04:17 49/40 mm/Hg (Lying l/arm) Diastolic Low of 60 exceeded Systolic Low of 90 exceeded Review of hospital information indicated the following: Hospital Course - final report " Nutrition Status: Severe Malnutrition in the context of Social or Environmental Circumstances; Severe protein-calorie malnutrition; >7.5% weight loss in 3 months (31% x 2 months)' Severe body fat loss; Severe muscle mass loss.Weight comorbidity: underweight. 83 year old female was found to have AKI (acute kidney injury happens when the kidneys suddenly can't filter waste products from the blood), hypernatremia, and admitted for further management. AM cortisol and B12 slightly elevated. Urine culture grew ESBL Klebsiella. Given IV fluids, with subsequent improvements in Creatine, sodium and calcium levels. Her mentation improved back to baseline. Renal failure, electrolyte	F 0684		

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F 0684 SS=E	Continued from page 70 derangement were treated however d/t ongoing encephalopathy and FTT Resident R128 did not tolerate adequate to sustain life." During an interview on 4/ 17/25, DON confirmed that the facility is capable of doing IV's or pushing fluids and had not identified hydration as a concern, that Resident R128 was having a change of condition prior to discharge to hospital, that the facility did not initiate labs to determine if there were any additional concerns for Creatine, sodium or calcium levels, and the facility failed to identify concerns for a potential AKI injury and that the facility failed to provide a quality of care for Resident R128. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.29(a)(c)(d)(j) Resident rights. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0684		

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F 0684 SS=E	Continued from page 71	F 0684		
F 0693 SS=D		F 0693		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0693 SS=D	Continued from page 72 483.25(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	1. Residents suffered no negative outcomes. 2. Orders were updated on residents with tube feeding to check tube feed residuals and elevating head of bed during administration. 3. Whole house audit was conducted on correct tube feed formula being hung and physician's orders relating to checking tube feed residuals and elevating head of bed during administration. 4. DON/designee to educate licensed staff on enteral feeding policies and enteral feeding physician's orders. 5. DON/designee to audit tube feed formula accuracy, labeled/dated, and appropriate orders 3x/week for 3 weeks, then 2x/week for 2 weeks, and 1xweek for 2 weeks. 6. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/16/2025**

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F 0693 SS=D	Continued from page 73 Based on review of facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that residents with an enteral feeding tube (a tube inserted in the stomach through the abdomen) received appropriate treatment and services to prevent potential complications for two of three residents (Residents R13 and Resident R35). Findings include: Review of facility policy "Care and Treatment of Feeding Tubes" dated 12/9/24, indicated the facility will utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Feeding tubes will be utilized according to physician orders. The resident's care plan will address the use of feeding tube, including strategies to prevent complications. In accordance with facility protocol, licensed nurses will monitor and check that the feeding tube is in the right location; tube placement will be verified before beginning a feeding and	F 0693		

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F 0693 SS=D	Continued from page 74 before administering medications. Review of Resident R13's clinical record indicated the resident was admitted to the facility on 9/4/24. Review of Resident R13's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/4/25, indicated diagnoses of high blood pressure, heart failure (heart doesn't pump the way it should) and chronic obstructive pulmonary disease (COPD-difficulty in breathing). Section K-Swallowing/Nutritional Status indicated the resident had a feeding tube while a resident. Review of Resident R13's physician orders dated 2/11/25, indicate nothing by mouth diet (NPO). Review of Resident R13's physician orders dated 2/12/25, indicate Enteral Feed every shift for nutrition Glucerna: 1.2 Calorie administer continuous via Pump at 70 milliliter (ML) per hour flush with 25ml per hour for 20 Hours per day or until total nutrient delivered (1400ml), Downtime:	F 0693		

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F 0693 SS=D	Continued from page 75 4:00 p.m. back up at 8:00 p.m. Review of Resident R13's medication administration record (MAR) for April 2025, failed to reveal enteral feeding tube orders prior to 4/15/25, which addressed appropriate treatment and services related to checking for tube feeding residuals, and elevate the head of bed during enteral feeding administration. Review of Resident R13's MAR for March 2025, failed to reveal enteral feeding tube orders prior to 4/15/25, which addressed appropriate treatment and services related to checking for tube feeding residuals, and elevate the head of bed during enteral feeding administration. During an interview on 4/18/25, at 9:18 a.m., the Director of Nursing (DON) confirmed that prior to physician orders for enteral feeding treatment and services entered on 4/15/25, Resident R13 did not have physician orders to check residuals, or to elevate the head of bed during enteral feeding	F 0693		

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F 0693 SS=D	Continued from page 76 administration. Review of clinical record revealed Resident R35 was admitted to facility initially 2/11/18, with current admission date of 1/12/21. Review of Resident 35's MDS dated 1/17/25, indicated diagnoses major depressive disorder (mental disorder characterized by a persistent low mood, loss of interest or pleasure in activities, and a range of emotional and physical problems), adult failure to thrive (condition characterized by a decline in physical and mental health, often seen in older adults), and dysphagia (difficulty swallowing foods or fluids). Section K- Swallowing/Nutritional Status indicated the resident had a feeding tube while a resident. Review of Resident R35's physician order dated 10/31/23, indicated nothing by mouth diet, NPO texture. Review of Resident R35's MAR for April 2025,	F 0693		

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F 0693 SS=D	Continued from page 77 indicated an enteral feed order every shift for feeding administer Osmolite 1.5 (a type of feeding formula that will supply a person with nutrients and minerals) via pump at 95 ml (milliliters) per hour for 16 hours daily for total 1620 ml, start at 6:00 p.m. every day, initiated 4/12/25, and discontinued 4/15/25. During an observation made on 4/14/25, at 12:45 p.m., enteral feeding tube formula of Osmolite 1.2 was hanging at Resident R35's bedside and failed to have a date written on the container when opened. During an interview conducted on 4/14/25, at 12:50 p.m., Registered Nurse (RN) Employee E27 confirmed that Resident R35's enteral tube feeding formula found hanging was incorrect per physician order and was undated when opened. Review of Resident R35's physician orders dated 4/15/25, indicated: - enteral feed order as needed verify placement. Flush enteral tube with at least 15 ml of water. Then	F 0693		

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 0693 SS=D	Continued from page 78 flush with 15 ml of water after administration of each medication. - enteral feed order every shift check residual, signs/symptoms intolerance every shift. Hold and notify of signs/symptoms intolerance. - enteral feed order every shift for feeding administer Osmolite 1.5 (Jevity 1.5 if Osmolite not available) via pump at 95 ml per hour for 16 hours daily for total 1520 ml. Start 6:00 p.m., down at 10:00 a.m. - enteral feed order every shift verify placement. Flush enteral tube with at least 15 ml of water. Then flush with 15 ml of water after administration of each medication. - enteral feed: elevate head of bed 30-45 degrees during feeding and for 30-45 minutes after every shift. During a follow-up observation conducted on 4/16/25, at 11:58 a.m., Resident R35's enteral feeding pole and floor area underneath were found dirty with what appeared to be spilled or leaked enteral formula which was dried covering the surface of the pole, 4 legs above the casters, and floor	F 0693		

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	395666	A. BLDG: 00 B. WING:	04/18/2025

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**

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F 0693 SS=D	Continued from page 79 below where pole was located. During an interview on 4/16/25, at 12;21 p.m., RN Employee E27 confirmed the above observation of Resident R35's dirty enteral pole and floor below with what appeared to be spilled or leaked enteral formula. Further review of Resident R35's MAR for April 2025, failed to reveal enteral feeding tube orders prior to 4/15/25, which addressed appropriate treatment and services related to verifying tube feeding placement, checking for tube feeding residuals, and elevate the head of bed during enteral feeding administration. Review of Resident R35's MAR for March 2025, failed to reveal enteral feeding tube orders prior to 4/15/25, which addressed appropriate treatment and services related to verifying tube feeding placement, checking for tube feeding residuals, and elevate the head of bed during enteral feeding administration.	F 0693		

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F 0693 SS=D	Continued from page 80 During an interview on 4/18/25, at 9:18 a.m., the DON confirmed that prior to physician orders for enteral feeding treatment and services entered on 4/15/25, Resident R35 did not have physician orders to verify tube feeding placement, to check residuals, or to elevate the head of bed during enteral feeding administration. During an interview on 4/18/25, at 2:30 p.m., the Nursing Home Administrator (NHA) and DON confirmed that the facility failed to ensure that residents with an enteral feeding tube (a tube inserted in the stomach through the abdomen) received appropriate treatment and services to prevent potential complications for two of three residents (Residents R13 and Resident R35). 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.	F 0693		

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F 0693 SS=D	Continued from page 81	F 0693		
F 0697 SS=D		F 0697		

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F 0697 SS=D	Continued from page 82 483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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 0697	1. The facility is unable to go back and make certain physician orders were followed and a resident received treatment and care in accordance with professional standards of practice. Resident R16 had no negative outcomes. 2. DON/designee will complete a 30-day lookback of all current resident's medication list, and audit carts for medication availability. 3. DON/designee to educate licensed staff on emergency medication supply, access to emergency medication supply, physician notification requirements of meds not available, and documentation requirements. 4. DON to audit medication availability 5x/week for 2 weeks, then 3x/week for 2 weeks, and 1x/week for 2 weeks. 5. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/20/2025**

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F 0697 SS=D	Continued from page 83 Based on review of facility policies and clinical records, observations, and resident and staff interviews, it was determined that the facility failed to provide effective pain management for one of four residents reviewed (Resident R16). Findings include: Review of the clinical record revealed that Resident R16 was admitted to the facility on 1/2/25, with diagnoses of right below the knee amputation, diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces), and peripheral vascular disease (a slow and progressive disease that impacts the blood vessels in the body outside the heart.) Review of Resident R16's care plan dated 1/3/25, revealed the resident was care planned for pain. Interventions included to administer medication per physician orders.	F 0697		

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 0697 SS=D	Continued from page 84 Review of Resident R16's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 1/7/25, indicated diagnoses were current. Review of Resident R16's physician order dated 4/11/25, indicated to administer 15 milligram of MS Contin (also known as morphine, a strong opioid pain medication for moderate to severe pain), one tablet by mouth, three times a day. During an interview on 4/14/25, at 2:20 p.m. it was revealed Resident R16 was experiencing phantom pain. Resident R16 stated the oxycodone was lowered, and morphine was ordered. Resident R16 had not received the morphine for pain. Resident R16 stated "I am not sure if it is in stock." Review of Resident R16's clinical record on 4/15/25, at 9:02 a.m. revealed Resident R16 failed to receive MS Contin as ordered at the following scheduled times. -4/13/25, at 2:00 p.m. -4/13/25, at 10:00 p.m.	F 0697		

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 0697 SS=D	Continued from page 85 -4/14/25, at 6:00 a.m. -4/14/25, at 2:00 p.m. It was indicated there was no medication in stock at this time. Interview with the Director of Nursing on 4/17/25, at 2:19 p.m. confirmed the facility failed to provide effective pain management for one of four residents reviewed (Resident R16). 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0697		
F 0698 SS=D		F 0698		

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F 0698 SS=D	Continued from page 86 483.25(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	1. Resident R22 did not experience any adverse effects, and is the only resident who goes to dialysis. 2. The Administrator will work with the dialysis center to develop and execute a contract outlining responsibilities of this facility and dialysis center. 3. NHA/designee to audit new admissions 1x/week for 3 weeks to ensure dialysis contracts are up to date. 4. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/20/2025**

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F 0698 SS=D	Continued from page 87 Based on review of resident clinical records and staff interviews, it was determined that the facility failed to maintain a complete record of a dialysis contract for one of two sampled residents (Resident R22). Findings include: Review of Resident R22's admission record indicated she was admitted 11/7/24. Review of Resident R22's MDS assessment (MDS: Minimum Data Set assessment-a periodic assessment of resident care needs) dated 2/12/25, indicated she had diagnoses that included end stage renal disease (gradual loss of kidney function), chronic obstructive pulmonary disease (COPD: a disease characterized by persistent respiratory symptoms involving breathlessness, coughing, and obstructed airflow to the lungs), and vascular dementia (a condition characterized by memory loss and progressive or persistent loss of intellectual functioning).	F 0698		

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F 0698 SS=D	Continued from page 88 Review of Resident R22's care plan dated 2/12/25, indicated she had dialysis three times a week Review of Resident R22's physician orders dated 2/28/25, indicated that she was ordered dialysis Monday, Wednesday and Friday. The location of the dialysis provider was on file. Review of Resident R22's nurse progress notes dated 4/14/25, indicated that she left the facility via wheelchair van to dialysis. Review of Resident R22's clinical records did not include a contract with the dialysis provider. Review of facility documents did not include a contract for the dialysis provider. During an interview on 4/15/25, at 9:24 a.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to maintain a complete record of a dialysis contract for Resident R22 as required.	F 0698		

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F 0698 SS=D	Continued from page 89 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 28 Pa. Code: 211.10(d) Resident care policies.	F 0698		
F 0699 SS=D		F 0699		

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F 0699 SS=D	Continued from page 90 483.25(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	1. Resident R278 no longer resides at the facility. 2. The records of other residents were audited for diagnoses of PTSD. 3. Care plans were reviewed and updated to include the history of what causes the PTSD, monitoring for specific signs and symptoms that triggers PTSD, and plan for appropriate interventions to mitigate the onset. 4. DON/designee to educate licensed staff on appropriate PTSD identification, triggers for awareness/prevention, and care planning PTSD. 5. DON/designee to audit new admissions 3x/week for 3 weeks and 2x/week for 2 weeks to monitor PTSD diagnosis, triggers, care plans. 6. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/20/2025**

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F 0699 SS=D	Continued from page 91 Based on review of facility policy, resident record review, and staff interviews, it was determined that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for one of two residents (Resident R278). Findings include: Review of facility policy "Comprehensive Care Plans" last reviewed 12/9/24, revealed it is the policy of the facility to develop and implement a comprehensive care plan for each resident, consistent with resident rights, that includes measureable objectives and timeframes to meet a resident's medica;, nursing, mental, and psychosocial needs and all services that are identified in the resident's comprehensive assessment and mee professional standards of quality. Review of the clinical record indicated Resident R278 was admitted to the facility on 4/1/25.	F 0699		

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F 0699 SS=D	Continued from page 92 Review of Resident R278's physician order dated 4/1/25, indicated to consult psychiatry. Review of Resident R278's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/7/25, indicated diagnoses of Post Traumatic Stress Disorder (PTSD- a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event), acquired absence of right leg below knee, and insomnia (difficulty staying or falling asleep). Review of Resident R278's care plan indicated that resident had PTSD but failed to identify what the triggers were and how to avoid them. During an interview on 4/14/25, at 9:55 a.m. Resident R278 stated "I have a history of PTSD from losing my leg." Resident R278 stated the facility failed to identify my triggers, and "I am afraid of going to hospitals and doctors." It was indicated the facility does not have a social worker. "Did they stick me in a zoo?" Resident R278 stated "I am	F 0699		

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F 0699 SS=D	Continued from page 93 more traumatized while being here." A review of Resident R278's clinical record on 4/17/25, at 10:57 a.m. revealed the facility failed to complete an assessment and identify Resident R278's PTSD triggers. There was no evidence Resident R278 was evaluated by psychiatry or had a psychology visit. Review of Resident R278's care plan failed to include a care plan for PTSD. During an interview on 4/17/25, at 2:22 p.m. the Director of Nursing confirmed the facility failed to identify Resident R278's PTSD triggers. The DON indicated normally the psychology provider comes in every Tuesday. The DON stated Resident R278 should have been evaluated on 4/6/25. It was indicated the psychology provider that rounds the facility came in on Tuesday and stated "I am going to roll." The DON stated "she's afraid of you guys." During an interview on 4/17/25, at 3:17 p.m. the Director of Nursing and Nursing Home Administrator confirmed the facility failed to identify	F 0699		

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F 0699 SS=D	Continued from page 94 PTSD triggers for Resident R278 to eliminate or mitigate any triggers that may cause re-traumatization for one of two residents (Resident R278). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.	F 0699		
F 0710 SS=D		F 0710		

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F 0710 SS=D	Continued from page 95 483.30(a)(1)(2) Resident's Care Supervised by a Physician §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by:	F 0710	1. The facility is unable to go back and make certain physician orders were signed off on timely and a resident received treatment and care in accordance with professional standards of practice. Resident R52 is no longer in facility 2.DON/designee to educate licensed nurses on verifying and implementing physician's orders and need for physician's signatures and verification of new orders prior to medication/treatment administered and notify physicians timely with change of conditions 3.DON to audit physician's orders/new orders, medication prior to implementation of new orders and timely notification of change in conditions 3x/week for 2 weeks, then 1x/week for 2 weeks. 4.Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/28/2025**

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: _____	04/18/2025

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F 0710 SS=D	Continued from page 96 Based on clinical record review, facility policy and interviews with staff, it was determined that the facility failed to ensure a medication was signed off by a physician prior to administering, and timely provide care and necessary treatment and services for one of two residents (Resident R52). Findings include: Review of the facility policy "Administering Medications" last reviewed 12/9/24, revealed medications are administered vin a safe and timely manner, and as prescribe. If dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associate with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns. Review of the facility policy "Provision of Quality	F 0710		

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F 0710 SS=D	Continued from page 97 Care" last reviewed 12/9/24, revealed the facility will ensure residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive care plans, and the resident's choices. Review of Cefpodoxime (antibiotic that treats bacterial infections) manufacturer guidelines dated 10/16/13, indicated for patients with severe renal impairment the dosing intervals should be increased to every 24 hours. Adverse interactions include gastrointestinal disturbances such as diarrhea, nausea, and vomiting. Review of Resident R52's admission record indicated he was admitted to the facility on 9/10/24, and readmitted on 2/20/25. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 2/4/25, included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), high blood pressure, and stage 4 chronic	F 0710		

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F 0710 SS=D	Continued from page 98 kidney disease (severe kidney function loss and high risk of complications and kidney failure). Review of Resident R52's physician order dated 2/2/25, indicated to administer 200 mg cefpodoxime, one tablet, by mouth twice daily related to stage 4 chronic kidney disease for 10 days. The order was created and confirmed by Registered Nurse, Employee E10. A further reviewed failed to indicate a physician reviewed and confirmed the order. Review of Resident R52's February 2025 Treatment Administration Record revealed the resident received cefpodoxime from 2/2/25, through 2/13/25. Review of Resident R52's clinical record revealed CRNP, Employee E20 evaluated Resident R52 on 2/12/25, for acute gastrointestinal pain. The resident had localized right and central region pain worse with palpitation that began that morning. The resident did not eat breakfast, had acute diarrhea,	F 0710		

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F 0710 SS=D	Continued from page 99 and was bloated. CRNP, Employee E52 indicated the resident's antibiotics may be contributing to the abdominal pain and the resident will remain on the antibiotics until 2/14/25. Review of Resident R52's clinical record revealed CRNP, Employee E20 evaluated Resident R52 on 2/13/25, for acute gastrointestinal pain. It was documented the antibiotics may be a possible contribution and the resident will remain on the antibiotics until 2/14/25. Review of Resident R52's progress note dated 2/13/25, at 9:03 p.m. indicated the resident called 911 5-6 times this evening requesting transport to the hospital for complaint of abdominal pain. Review of Resident R52's progress note dated 2/14/25, at 1:17 a.m. revealed the 911 operator called stating Resident R52 called them to go to the emergency room. RN Supervisor, Employee E24 went to see the resident and Resident R52 complained of severe back and kidney pain with	F 0710		

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F 0710 SS=D	Continued from page 100 severe diarrhea. "Crying to go to hospital." Review of Resident R52's progress note dated 2/14/25, at 2:38 a.m. revealed the resident was transferred to the hospital. Review of Resident R52's progress note dated 2/14/25, at 3:00 a.m. indicated the emergency room nurse called concerned about the resident receiving cefpodoxime. It was confirmed the resident received cefpodoxime from 2/2/25, until 2/13/25. Review of Resident R52's progress note dated 2/14/25, at 8:31 a.m. revealed the resident was admitted to the hospital with diagnoses of pyelonephritis (kidney infection). During an interview on 4/16/25, at 11:22 a.m. CRNP, Employee E20 was asked what is the process for sending a resident out to the hospital, and stated the provider would be notified and orders are obtained to treat or send out to the hospital. When asked who confirms physician	F 0710		

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F 0710 SS=D	Continued from page 101 orders, CRNP, Employee E20 stated that's "a question for the DON." During an interview on 4/16/25, at 11:34 a.m. the Director of Nursing stated each morning an order recap report is reviewed and the DON confirms the orders if nothing stands out. "I'm not a pharmacist" the DON stated. The DON stated all orders must be signed by a provider. The DON confirmed Resident R52's cefpodoxime was not signed off by a physician. During an interview on 4/18/25, at 8:59 a.m. the NHA confirmed the facility failed to ensure Resident R52's cefpodoxime was signed off by a physician prior to administering, and timely provide care and necessary treatment and services for one of two residents (Resident R52). 28 Pa. Code:211.12(d)(5) Nursing services.	F 0710		

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F 0726 SS=E		F 0726		

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F 0726 SS=E	Continued from page 103 483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:	F 0726	1. Employees Registered Nurse (RN) Employee E16, Licensed Practical Nurse (LPN) Employee E25, and Registered Nurse (RN) Employee E26 will receive mandatory education including infection prevention and control, fire prevention and safety, disaster preparedness, resident abuse, resident confidential information, Quality assurance, resident psychosocial needs, restorative nursing techniques, resident rights, cultural competency, and communication. 2. HR Director/designee to audit employee files to determine the mandatory education including infection prevention and control, fire prevention and safety, disaster preparedness, resident abuse, resident confidential information, Quality assurance, resident psychosocial needs, restorative nursing techniques, resident rights, cultural competency, and communication that needs to be completed by each employee. 3. Future mandatory education will	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/20/2025**

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F 0726 SS=E	Continued from page 104	F 0726	be completed by employees annually. HRD/designee will audit employee files to ensure the annual mandatory education is completed monthly x12 months. Those employees not completing the education will be removed from the schedule. 5. Results to be submitted to QAPI for review and approval.	

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F 0726 SS=E	Continued from page 105 Based on review of facility policy, nursing staff personnel records, nurse training documentation and staff interview, it was determined that the facility failed to ensure that nursing staff received annual in-service education for three out of five sampled nursing personnel records (Registered Nurse (RN) Employee E16 , Licensed Practical Nurse (LPN) Employee E25, and Registered Nurse (RN) Employee E26). Findings include: The facility "Training requirements" policy last reviewed on 12/9/24, indicated that the facility will develop, implement and maintain an effective training program for all new and existing staff. Training contents includes, at the minimum communication, resident rights, elements of the facility's QAPI (quality assurance and performance improvement), infection control, ethics, behavioral health, dementia management, abuse/ neglect, and safety and emergency procedures.	F 0726		

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F 0726 SS=E	Continued from page 106 Review of Registered Nurse (RN) Employee E16 personnel record indicated she was hired on 11/3/10. Review of Licensed Practical Nurse (LPN) Employee E25 personnel record indicated she was hired on 12/1/03. Review of Registered Nurse (RN) Employee E26 personnel record indicated she was hired on 9/4/14. Review of personnel records for Registered Nurse (RN) Employee E16 , Licensed Practical Nurse (LPN) Employee E25, and Registered Nurse (RN) Employee E26 did not include annual in-services for the following subjects: infection prevention and control, fire prevention and safety, disaster preparedness, resident abuse, resident confidential information, Quality assurance, resident psychosocial needs, restorative nursing techniques, resident rights, cultural competency, and communication.	F 0726		

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F 0726 SS=E	Continued from page 107 During an interview on 4/18/25, at 11:28 a.m . the Human Resources Employee E5 confirmed that the facility failed to ensure that Registered Nurse (RN) Employee E16 , Licensed Practical Nurse (LPN) Employee E25, and Registered Nurse (RN) Employee E26 received annual in-service education as required. 28 Pa. Code: 201.14(1) Responsibility of licensee. 28 Pa. Code: 201.18(a)(3) Management.	F 0726		
F 0740 SS=D		F 0740		

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F 0740 SS=D	Continued from page 108 483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by:	F 0740	1. Resident R16 will be seen by psych services. 2. NHA to educate Social Services/designee on behavioral health services and interventions and ensure psych services list is discussed at IDT meeting. 3. Social Services/designee to audit psych list to ensure services are provided as scheduled. 4. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/20/2025**

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F 0740 SS=D	Continued from page 109 Based on clinical record review and staff and resident interview, it was determined that the facility failed to provide behavioral health interventions for a resident to maintain the highest practicable mental well-being for one of four residents reviewed for behavioral concerns (Resident 16). Findings include: Review of the clinical record revealed that Resident R16 was admitted to the facility on 1/2/25. Review of Resident R16's active physician order dated 1/2/25, indicated to consult psychiatry. Review of Resident R16's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 1/7/25, indicated diagnoses of right below the knee amputation, diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces) , and peripheral vascular disease (a slow and progressive disease that impacts	F 0740		

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F 0740 SS=D	Continued from page 110 the blood vessels in the body outside the heart.) Review of Resident R16's care plan dated 1/14/25, revealed the resident uses an antidepressant medication due to major depressive disorder. Interventions included to monitor signs and symptoms of depression and refer to psychology services as appropriate. During an interview on 4/14/25, at 2:25 p.m. Resident R16 was observed with a right leg amputation and expressed "God hates me." Resident R16 explained the amputation occurred around Thanksgiving. No one has seen me for psychology services. Review of Resident R16's clinical record on 4/17/25, at 9:17 a.m. failed to provide evidence Resident R16 was evaluated by psychiatry as ordered. During an interview on 4/17/25, at 2:22 p.m. the Director of Nursing indicated normally the	F 0740		

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F 0740 SS=D	Continued from page 111 psychology provider comes in every Tuesday. It was indicated the psychology provider that rounds the facility came in on Tuesday and stated I am going to roll. The DON stated the psychology provider is "afraid of you guys." During an interview on 4/17/25, at 3:17 p.m. the Nursing Home Administrator and DON confirmed the facility failed to provide behavioral health interventions for a resident to maintain the highest practicable mental well-being for one of four residents reviewed for behavioral concerns (Resident 16). 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0740		
F 0745 SS=D		F 0745		

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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 0745 SS=D	Continued from page 112 483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services 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 0745	1. Resident R128 will be seen by psych services. 2. NHA to educate Social Services/designee on behavioral health services and interventions. 3. Social Services/designee to conduct whole house audit of psych diagnoses to assess for behavioral health services and interventions. 4. SSD/Designee will audit new admissions weekly for 2 weeks, then 1x/week for 2 weeks to ensure residents who are in need of psych services as a baseline receive them. 4. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0745 SS=D	Continued from page 113 Based on review of clinical records and staff interview it was determined that the facility failed to provide medically related social services to one of two residents reviewed (Resident R128). Findings include: Review of the clinical record indicated that Resident R128 was admitted on 1/18/25. Review of Resident R128 MDS indicated a diagnosis of depression (a common and serious mental disorder that negatively affects how you feel, think, act, and perceive the world), hypokalemia (potassium blood level low), and seizure disorder (a brain condition that causes recurring seizures). Review of Resident R128 physician orders dated 1/18/25, indicated to administer Selegeline Transdermal Patch 24 Hour 12 MG/24 HR, one patch transdermally (on top of skin) at bedtime for depression related to major depressive disorder	F 0745		

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 0745 SS=D	Continued from page 114 Review of Resident R128 MAR (medication administration record) and review of clinical progress notes indicated missed doses of selegeline for multiple days: 1/18/25 thru 1/26/25. Review of Resident R128 clinical record indicated selegeline was discontinued - with no additional medication for depression prescribed. Additional review of Resident R128 clinical record failed to indicate any referrals for psych services for depression diagnosis. During an interview on 4/17/25, 1:50 p.m. DON (Director of Nursing) confirmed that the medication was discontinued and the facility did not provide referrals for psych services related to the depression diagnosis. 28 Pa. Code 211.16 (a) Social services.	F 0745		

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F 0755 SS=E		F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0755 SS=E	Continued from page 116 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	1. The facility is unable to go back and make certain physician orders were followed and a resident received treatment and care in accordance with professional standards of practice. Residents R51 and R128 had no adverse reactions. 2. DON completed whole house investigation on missing medication. MD was notified of any missed medication and discussed new orders received when medication is unavailable. Staff interviewed on medication re-ordering. Licensed staff educated on medication re-ordering. 3. DON/designee will complete a 30-day lookback of all current resident's medication list, and audit carts for medication availability. 4. DON/designee to educate licensed staff on emergency medication supply, access to emergency medication supply, physician notification requirements of meds not available, and documentation requirements. 5. DON/designee to audit RX NOW machine 1x/week for 3 weeks,	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/19/2025**

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F 0755 SS=E	Continued from page 117 This REQUIREMENT is not met as evidenced by:	F 0755	then 1x/month for 3 months. 6. DON to audit cart medication availability 5x/week for 2 weeks, then 3x/week for 2 weeks, and 1x/week for 2 weeks. 7. Results to be submitted to QAPI for review and approval.	

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F 0755 SS=E	Continued from page 118 Based on review of facility policy, clinical records, and staff interviews it was determined that the facility failed to implement pharmaceutical services to ensure accurate provision of medications for one of four residents (Residents R51 and Resident R128). Findings include: Review of the facility policy, "Pharmacy Services" last reviewed 12/9/24, indicated to ensure pharmaceutical services, whether employed by the facility or under an agreement, are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. The facility will maintain a limited supply of medications for emergency or after-hours situations in accordance with facility policy and applicable laws. Review of the facility policy "Unavailable Medications" last reviewed 12/9/24, indicates the facility maintains a contract with a pharmacy provider to supply the facility with routine, prn, and	F 0755		

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F 0755 SS=E	Continued from page 119 emergency medications. The facility shall follow established procedures for ensuring residents have a sufficient supply of medication. Review of Residents R51's admission record indicated admission to the facility on 8/28/23. Review of Residents R51's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 3/10/25, indicated the diagnoses of high blood pressure, anxiety and depression. During an observation completed on 4/16/25, at 8:51 a.m. Registered Nurse (RN)Employee E27 was preparing medications for Resident R51. RN Employee E27 was not able to find Resident R51's Zoloft (used to treat depression and anxiety). Upon asking RN Employee E27 the process for unavailable medications she replied " I will have to get it pulled from the pyxis (drug distribution system), I will have to get someone who has access to the machine". RN Employee E27 stated the machine was on the first floor. RN Employee E27	F 0755		

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F 0755 SS=E	Continued from page 120 asked RN Employee E10 to assist with obtaining the medication. Upon pulling the medication from the pysis machine RN Employee E10 opened the drawer to dispense and discovered only one pill was available at 25 milligram (mg). The machine screen visualized indicated that four 25mg tablets should have been in the drawer. RN Employee E10 stated "the screen says four but only one is available in here it looked like we had enough I don ' t know why it's off". RN Employee indicated that pharmacy would have to be called to have it delivered. During an interview completed on 4/16/25, at 9:37 a.m. with the Nursing Home Administrator (NHA) and Director of Nursing (DON) upon asking the procedure for unavailable medications not available in the pyxis machine the DON indicated the pharmacy comes in around 11:00 p.m. "our cut off time is 5:00 p.m.". Upon inquiring the process for unavailable medications and the utilization of a local backup pharmacy the DON replied "we don't have a backup pharmacy if you do a stat they will have a run around 1:00 p.m. or 2:00 p.m. then again at	F 0755		

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F 0755 SS=E	Continued from page 121 midnight we use Phar -America we need to call at midmorning for the run and stated "I'm going to be making some calls now and get the pharmacy here". During an interview completed on 4/16/25 at 10:54 a.m. upon asking the pharmacy director (PD) Employee E28 about a local back up pharmacy she replied "we can use any local pharmacy and get it filled". Upon asking PD Employee E28 about the restocking/monitoring of the pyxis machine as well as medication reconciliation concerning off counts/discrepancies replied "we pull a report on Mondays and Wednesdays for the restock. The facility can also call and let us know when the medication needs to be refilled and we can send it out on the run, the nurses can then put it in the pyxis" Upon further inquiry concerning medication discrepancy concerning the Zoloft stated "any time the count is off they should notify the pharmacy and do a discrepancy, we have not received any phone calls". Further inquiry into the Zoloft count PD Employee E28 replied" I pulled up the report and it indicated that seven Zoloft tablets were available"	F 0755		

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F 0755 SS=E	Continued from page 122 upon inspection of the Zoloft available in the pyxis the machine at that time showed "0" and stated "I don ' t think I can pull anything off this machine to indicate who the user was, they should put in how much they are taking and it is automatically adjusted". Review of the pharmacy provided pyxis inventory reports indicated the following medications at zero (0). Lantus Solostar Insulin Pen (long acting insulin to improve blood sugar control) Levothyroxine 0.088 mg (used to treat hypothyroidism-thyroid gland does not produce enough thyroid hormone) Humalog Insulin Pen (fast acting insulin used to lower blood sugars) Advair Diskus inhaler (prevents asthma attacks and Chronic Obstructive Pulmonary Disease (COPD-difficulty in breathing) flare ups. Ventolin inhaler (helps with trouble breathing) Bumetanide 0.5 mg tablets (diuretic- reduces fluid retention) Bumetanide 1 mg tablets (diuretic- reduces fluid retention)	F 0755		

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F 0755 SS=E	Continued from page 123 The PD Employee E28 stated "someone is coming down now, if the facility made us aware of the empty medications it would have been sent with the run, there is no reason for these to be at zero". During an interview completed on 4/17/25, at 10:12 a.m. the Pharmacy Technician Employee E29 was at the pyxis machine restocking the medications. Upon asking how often the machine is restocked stated "it depends on the list and time restraints, and review of the list about once a month, I get the list every Wednesday morning so I lock once a week, I'm only here two days a week , someone else can be looking at it, but I'm not aware of that. I just put the medications in the machine, the facility has not called to request any medications, I don ' t know if that ever happened. Upon asking about medication discrepancies Pharmacy Technician Employee E29 stated any discrepancies in the drawers should be taken care of by the facility and pharmacy director, if it is a controlled substance it should be immediately".	F 0755		

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F 0755 SS=E	Continued from page 124 During an interview on 4/17/25, at 3:19 p.m. the Nursing Home Administration and Director of Nursing confirmed that the facility failed to implement pharmaceutical services to ensure accurate provision of medications for one of four residents. (Resident R51). Review of the clinical record indicated that Resident R128 was admitted on 1/18/25. Review of Resident R128 MDS dated 1/24/25, indicated a diagnosis of depression (a common and serious mental disorder that negatively affects how you feel, think, act, and perceive the world), hypokalemia (potassium blood level low), and seizure disorder (a brain condition that causes recurring seizures). Review of Resident R128 physician orders indicted the following: Dorzolamide HCl-Timolol Mal Ophthalmic Solution	F 0755		

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F 0755 SS=E	Continued from page 125 2-0.5 % (Dorzolamide HCl-Timolol Maleate) Instill 1 drop in both eyes two times a day for Glaucoma Latanoprost Ophthalmic Solution 0.005 % (Latanoprost) Instill 1 drop in both eyes at bedtime for glaucoma related to UNSPECIFIED GLAUCOMA (H40.9 Selegeline HCl Oral Capsule 5 MG (Selegeline HCl) Give 1 capsule by mouth two times a day related to PARKINSON'S DISEASE WITHOUT DYSKINESIA, WITHOUT MENTION OF FLUCTUATIONS (G20. Selegeline Transdermal Patch 24 Hour 12 MG/24 HR (Selegeline) Apply 1 patch transdermally at bedtime for Depression related to MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED (F33.9)	F 0755		

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F 0755 SS=E	Continued from page 126 Zonisamide Oral Capsule 25 MG (Zonisamide) Give 25 mg by mouth in the morning for Seizures Pharmacy Review of clinical record progress notes indicated the following medications were not available and not given: 1/19/25 11:13: Dorzolamide HCl-Timolol Mal Ophthalmic Solution 2-0.5 % Instill 1 drop in both eyes two times a day for Glaucoma Awaiting arrival from pharmacy 1/19/25 22:00: Selegeline Transdermal Patch 24 Hour 12 MG/24 HR Apply 1 patch transdermally at bedtime for Depression awaiting arrival from pharmacy	F 0755		

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F 0755 SS=E	Continued from page 127 1/20/25 20:40 clonidine HCl Oral Tablet 0.1 MG Give 0.1 mg by mouth two times a day for Hypertension on order 1/20/25 20:41: Dorzolamide HCl-Timolol Mal Ophthalmic Solution 2-0.5 % Instill 1 drop in both eyes two times a day for Glaucoma waiting for medication to be delivered Selegeline Transdermal Patch 24 Hour 12 MG/24 HR Apply 1 patch transdermally at bedtime for Depression related to MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED (F33.9) waiting for medication to be delivered 1/21/25 13:58: Dorzolamide HCl-Timolol Mal Ophthalmic Solution 2-0.5 %	F 0755		

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F 0755 SS=E	Continued from page 128 Instill 1 drop in both eyes two times a day for Glaucoma on order from pharmacy 1/21/25 20:36: Selegeline Transdermal Patch 24 Hour 12 MG/24 HR Apply 1 patch transdermally at bedtime for Depression related to MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED (F33.9) not avail Review of Resident R128 progress notes dated 1/22/25, signed by NP (Nurse Practioner) failed to include any mention of the missed medication. 1/22/25 21:35: Dorzolamide HCl-Timolol Mal Ophthalmic Solution 2-0.5 % Instill 1 drop in both eyes two times a day for Glaucoma on order, waiting for medication to be delivered	F 0755		

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: _____	04/18/2025

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**

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F 0755 SS=E	Continued from page 129 1/22/25 21:36: Selegeline Transdermal Patch 24 Hour 12 MG/24 HR Apply 1 patch transdermally at bedtime for Depression related to MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED (F33.9) on order 1/22/25 21:36: Selegeline Transdermal Patch 24 Hour 6 MG/24 HR Apply 12 mg transdermally at bedtime for Parkinson's related to PARKINSON'S DISEASE WITHOUT DYSKINESIA, WITHOUT MENTION OF FLUCTUATIONS (G20.A1) STAT DELIVERY on order 1/24/25 20:27: Selegeline Transdermal Patch 24 Hour 12 MG/24 HR	F 0755		

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F 0755 SS=E	Continued from page 130 Apply 1 patch transdermally at bedtime for Depression related to MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED (F33.9) on order 1/24/25 20:49: Dorzolamide HCl-Timolol Mal Ophthalmic Solution 2-0.5 % Instill 1 drop in both eyes two times a day for Glaucoma on order Review of clinical record progress notes dated 1/25/25, indicated Selegeline Transdermal Patch 24 Hour 12 MG/24 HR, was discontinued. Review of clinical record progress notes dated 1/26/25, indicated "Resident is alert and oriented x2 with some confusion. Resident is on thin liquids and regular texture diet. Resident will take medications whole, but will sometimes request to have them crushed in pudding. Resident has a history of	F 0755		

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: _____	04/18/2025

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F 0755 SS=E	Continued from page 131 Parkinson's and does experience tremors from time to time." 1/28/25 20:30: Dorzolamide HCl-Timolol Mal Ophthalmic Solution 2-0.5 % Instill 1 drop in both eyes two times a day for Glaucoma on order 1/29/25 21:59: Dorzolamide HCl-Timolol Mal Ophthalmic Solution 2-0.5 % Instill 1 drop in both eyes two times a day for Glaucoma awaiting arrival from pharmacy 2/1/25 20:17: Selegeline HCl Oral Capsule 5 MG Give 1 capsule by mouth two times a day related to PARKINSON'S DISEASE WITHOUT DYSKINESIA, WITHOUT MENTION OF FLUCTUATIONS (G20.A1)	F 0755		

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F 0755 SS=E	Continued from page 132 reordered 2/4/25 20:51: Amantadine HCl Oral Capsule Give 100 mg by mouth two times a day for Blood Pressure related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) not on hand, waiting for medication to be delivered. During an interview on 4/17/25, at 2:00 p.m. DON confirmed the above missed doses of selegeline HCI oral capsule, Amantadine, selegeline, dorzolamide, were not in the facility and although ordered resident went without the medication as ordered and the facility failed to provide accurate pharmaceutical services. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.9 (a)(1)(k)(l)(1)(2)(3)(4) Pharmacy services 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(1)(5) Nursing services.	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395666	A. BLDG: __00_____ B. WING: _____	04/18/2025

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F 0755 SS=E	Continued from page 133	F 0755		
F 0756 SS=E	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	F 0756	1. Residents experienced no adverse effects. A whole house audit will be conducted on residents' pharmacy recommendations, and addressed as appropriate. 2. Facility pharmacy was educated on completion of resident drug regimen reviews. 3. NHA to educate DON/designee on drug regimen review process. 4. DON/designee to audit drug regimen reviews of 20% of residents weekly x4 weeks then monthly x 4 months. 5. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/22/2025**

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 0756 SS=E	Continued from page 134 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 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)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0756 SS=E	Continued from page 135 Based upon review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure that any irregularities submitted in the medication regimen reviews (MRR) by pharmacy were acted upon timely for two out of two residents (Resident R2 and R69). Findings include: Review of facility policy "Medication Regimen Review" last reviewed on 12/9/24, indicated the drug regimen is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart. The MMR, or drug regimen review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risk associated with medication. The MMR includes: a. Review of the medical record in order to prevent, identify, report, and resolve medication related problems, medication errors, or other irregularities. b. Collaboration with other members of the	F 0756		

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 0756 SS=E	Continued from page 136 interdisciplinary team, including the resident, their family and/or resident representative. The requirements associated with the MRR apply to all residents, whether short or long stay. The pharmacist shall communicate any irregularities to the facility in the following ways: a. Verbal communication to the attending physician, the facilities medical director and or the staff of any urgent needs. b. Written communication to the attending physician, the facilities medical director and the director of nursing. Written communications from the pharmacist shall become a permanent part of the resident's medical record. Review of Resident R2's clinical record indicated the resident was admitted to the facility on 7/24/20. Review of Resident 2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/3/25, indicated diagnoses of Alzheimer's disease (most common cause of dementia, characterized by a	F 0756		

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F 0756 SS=E	Continued from page 137 progressive decline in memory, thinking, and behavior), heart failure, and diabetes mellitus (endocrine disease characterized by sustained high blood glucose levels). Section N0415 - Medications high risk drug classes use and indication indicates resident is taking antipsychotic, antianxiety, and antidepressant medications. Review of Resident R2's physician order dated 2/17/25, indicated Escitalopram Oxalate (Lexapro-medication used to increase Serotonin in the brain that influences mood, sleep, digestion and more) oral tablet 10 milligram (MG) Give 1 tablet by mouth at bedtime related to major depressive disorder, recurrent, severe with psychotic symptoms. Review of Resident R2's physician order dated 2/17/25, indicated Quetiapine Fumarate (Seroquel - medication used to balance dopamine and Serotonin levels in the brain, helping to calm psychotic thoughts and improve mood) oral tablet 100 MG Give 1 tablet by mouth three times a day for mood	F 0756		

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 0756 SS=E	Continued from page 138 disorder related to major depressive disorder, recurrent, severe with psychotic symptoms. Review of Resident R2's physician order dated 4/11/25, indicated Lorazepam (Ativan - medication used for anxiety disorders) oral concentrate 2 milligram per milliliter (MG/ML) Give 0.25 ML by mouth every four hours as needed for anxiety related to Alzheimer's disease, schizoaffective disorder, anxiety disorder. During a review of Resident R2's medication administration record (MAR) on 4/18/25, the above orders were active. During a review of Resident 2's progress notes on 04/18/25, at 8:39 a.m. indicated: - Pharmacy Drug Regimen Review was completed on 10/15/24, Medical chart reviewed - recommendations made. - Pharmacy Drug Regimen Review was completed on 12/14/24, Medical chart reviewed - recommendations made.	F 0756		

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F 0756 SS=E	Continued from page 139 - Pharmacy Drug Regimen Review was completed on 1/16/25, Medical chart reviewed - recommendations made. - Pharmacy Drug Regimen Review was completed on 2/10/25, Medical chart reviewed - recommendations made. - Pharmacy Drug Regimen Review was completed on 3/11/25, Medical chart reviewed - recommendations made. A review of Resident R2's clinical record on 4/18/25, failed to include the above information containing the recommendations that were made by pharmacy drug regimen review. A review of Resident R69's clinical record on 4/15/25, failed to include the above information containing the recommendations that were made. Review of Resident R69's clinical record indicated the resident was admitted to the facility on 1/29/25. Review of Resident R69's MDS dated 2/4/25,	F 0756		

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F 0756 SS=E	Continued from page 140 indicated diagnoses of high blood pressure, anxiety and depression. Section N0415 - Medications high risk drug classes use and indication indicates resident is taking antianxiety and antidepressant medications. Review of Resident R69's physician orders dated 3/4/25, indicated Escitalopram Oxalate (Lexapro-medication used to increase Serotonin in the brain that influences mood, sleep, digestion and more) oral tablet 20 milligram (MG) Give one tablet by mouth one time a day related to major depressive disorder. Review of Resident R69's physician orders dated 3/14/25, indicated Lorazepam (Ativan - used for anxiety disorders) give one tablet by mouth three times a day for anxiety Review of Resident R69's physician order dated 3/29/25, indicated buspirone HCl Oral Tablet 10 MG (Buspar--an antianxiety medication that effects chemicals in the brain) Give one tablet by mouth two	F 0756		

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F 0756 SS=E	Continued from page 141 times a day for anxiety. During a review of Resident R69's medication administration record (MAR) on 4/15/25, the above orders were active. During a review of Resident R69's progress notes on 04/16/25, at 10:44 a.m. indicated: - Pharmacy Drug Regimen Review was completed on 2/10/25, Medical chart reviewed - recommendations made. - Pharmacy Drug Regimen Review was completed on 3/11/25, Medical chart reviewed - recommendations made. A review of Resident R69's clinical record on 4/15/25, failed to include the above information containing the recommendations that were made. During an interview completed on 4/17/25, at 11:33 a.m. the Director of Nursing (DON) confirmed Resident R69's recommendations for the physician response for the MRR's were not available in	F 0756		

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F 0756 SS=E	Continued from page 142 resident R69's clinical record. Upon asking what is the procedure in place for the MRR's, the DON stated "the pharmacy faxes them over and I hand deliver to the physician, it varies, if I see them in the medication delivery box I grab them" upon further asking the DON about monitoring the physician responses he replied " I don't know a lot about it, there is not a process in place for the MRR's. During an interview on 4/18/25, at 2:30 p.m., the DON confirmed the facility failed to ensure that any irregularities submitted in the medication regimen reviews (MRR) by pharmacy were acted upon timely for two out of two residents (Resident R2 and R69). 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.5(f) Clinical records. 28 Pa. Code 211.9(a)(1) Pharmacy services. 28 Pa. Code 211.12(c)(d)(1)(2)(5) Nursing services.	F 0756		

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F 0756 SS=E	Continued from page 143	F 0756		
F 0758 SS=E		F 0758		

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 0758 SS=E	Continued from page 144 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 0758	1. Resident R2 did not experience any adverse effects. R2's PRN order was fixed to 14 day time limit. Care plan updated and facility implemented documentation of monitoring of med effectiveness. 2. DON/designee to educate licensed staff on PRN orders for psychotropic drugs limited to 14 days and to monitor effectiveness or adverse consequences of psychotropic medications and to document monitoring/med effectiveness. 3. DON/designee to conduct house audit on residents on psychotropic meds to ensure all PRN orders have the required 14 day time limit and care plan/documentation regarding med effectiveness. 4. DON/Designee to audit psychotropic drug usage to ensure PRN orders have the required 14 day time limit and care plan/documentation regarding med effectiveness daily x 1 week, 3x/week for 2 weeks, then monthly x 2 months. 5. Results to be submitted to QAPI	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/22/2025**

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: _____	04/18/2025

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F 0758 SS=E	Continued from page 145 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758	for review and approval.	

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F 0758 SS=E	Continued from page 146 Based on facility policy, clinical record review, and staff interview it was determined the facility failed to ensure PRN orders for psychotropic drugs are limited to 14 days, and failed to monitor the effectiveness or adverse consequences of psychotropic medication use for one of three residents (Resident R2) reviewed. Findings Include: Review of facility policy "Use of Psychotropic Medications" dated 12/9/24, indicated this policy is to ensure that residents only receive psychotropic mediations when other nonpharmacological interventions are clinically contraindicated. Additionally, these medication should only be used to treat the resident's medical symptoms and not used for disciple or staff convenience. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include, but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics.	F 0758		

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F 0758 SS=E	Continued from page 147 Psychotropic medications are to be used only when a practioner determines that the medication(s) is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). Review of Resident R2's clinical record indicated the resident was admitted to the facility on 7/24/20. Review of Resident 2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/3/25, indicated diagnoses of Alzheimer's disease (most common cause of dementia, characterized by a progressive decline in memory, thinking, and behavior), heart failure, and diabetes mellitus (endocrine disease characterized by sustained high blood glucose levels). Section N0415 - Medications high risk drug classes use and indication indicates resident is taking antipsychotic, antianxiety, and antidepressant medications.	F 0758		

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F 0758 SS=E	Continued from page 148 Review of Resident R2's physician order dated 2/17/25, indicated Escitalopram Oxalate (Lexapro-medication used to increase Serotonin in the brain that influences mood, sleep, digestion and more) oral tablet 10 milligram (MG) Give 1 tablet by mouth at bedtime related to major depressive disorder, recurrent, severe with psychotic symptoms. Review of Resident R2's physician order dated 2/17/25, indicated Quetiapine Fumarate (Seroquel - medication used to balance dopamine and Serotonin levels in the brain, helping to calm psychotic thoughts and improve mood) oral tablet 100 MG Give 1 tablet by mouth three times a day for mood disorder related to major depressive disorder, recurrent, severe with psychotic symptoms. Review of Resident R2's physician order dated 4/11/25, indicated Lorazepam (Ativan - medication used for anxiety disorders) oral concentrate 2 milligram per milliliter (MG/ML) Give 0.25 ML by mouth every four hours as needed for anxiety	F 0758		

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F 0758 SS=E	Continued from page 149 related to Alzheimer's disease, schizoaffective disorder, anxiety disorder. Review of Resident R2's medication administration record (MAR) for April 2025, indicated Lorazepam oral concentrate 2 MG/ML Give 0.25 ML by mouth every twelve hours as needed for anxiety with a start date of 6/7/24, end date (discontinue date) 4/11/25. Review of Resident R2's clinical record from 6/7/24, through 4/10/25, failed to indicate a rationale why the 0.25 ML of 2 MG/ML lorazepam by mouth every twelve hours as needed for anxiety, was ordered for more than 14 days without a stop date. Review of Resident R2's care plan initiated on 11/9/22, identified focus due to antipsychotic medication use; goal - resident will remain free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbances, constipation/impaction, or cognitive/behavioral	F 0758		

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F 0758 SS=E	Continued from page 150 movement impairment through next review date; and interventions - monitor/record/report side effects and effectiveness. Continued review of Resident R2's care plan initiated 11/14/23, identified focus due to use of antianxiety medication; goal - resident will be free from discomfort or adverse reaction related to antianxiety therapy through next review; and interventions - monitor/document side effects and effectiveness. Continued review of Resident R2's care plan initiated 11/14/23, identified focus due to antidepressant medication use; goal - resident will be free from discomfort or adverse reactions related to antidepressant therapy through next review date; and interventions - monitor/document side effects and effectiveness. Review of Resident R2's clinical record failed to reveal any documented evidence that the facility was monitoring the effectiveness or adverse	F 0758		

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F 0758 SS=E	Continued from page 151 consequences of psychotropic medication use for antipsychotic, antianxiety, and antidepressant medications. During an interview on 4/18/25, at 10:45 a.m., the Director of Nursing (DON) confirmed that the facility failed to ensure PRN orders for psychotropic drugs are limited to 14 days, and failed to monitor the effectiveness or adverse consequences of psychotropic medication use for one of three residents (Resident R2) reviewed. 28 Pa code 211.10(c) Resident care policies 28 Pa Code 211.5(f) Medical records 28 Pa. 211.12(c)(d)(1)(3)(5) Nursing services	F 0758		
F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 152 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	1. DON/designee to complete whole house audit for medications at bedside, med rooms, med fridges and under sink storage areas. 2. Residents experienced no adverse effects. Resident R69 was not self-administering any medications or treatments during observation. 3. All medications not properly stored in medication carts/rooms were disposed of per policy protocol immediately. 4. DON/designee to educate licensed staff on medication administration and medication storage, including labeling and dating of meds/treatments upon opening for accurate use by date. 5. DON/designee to audit medication carts and rooms for appropriate med storage, meds at bedside and proper med labeling/dating upon opening 3x/week for 2 weeks, then 1x/week for 4 weeks. 6. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/22/2025**

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F 0761 SS=D	Continued from page 153 Based on review of facility policies, observations, and staff interviews it was determined that the facility failed to properly store medical supplies and biologicals in one of two medication rooms (second floor medication room) and two of four medication carts (first floor west and second floor west medication cart) failed to date open medications in two of four medication carts (first floor west and second floor west medication cart) and treatment medications were found unsecured at a resident's bedside for one of four residents (Resident R69). Findings include: Review of the facility policy "Medication Storage" last reviewed 12/9/24, indicate it is the policy of this facility to ensure all medications housed on premises will be stored in the pharmacy and/or medication rooms according to the manufactures recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. External products disinfectants and drugs used for external use are	F 0761		

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F 0761 SS=D	Continued from page 154 stores separately from internal and injectable medications. Review of the facility policy " Resident Self-Administration of Medications" last reviewed 12/9/24, indicate bedside medication storage is permitted only when it does not present a risk to confused residents who wander into other resident's rooms. Review of Resident R69's clinical record indicated the resident was admitted to the facility on 1/29/25. Review of Resident R69's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/4/25, indicated diagnoses of high blood pressure, anxiety and depression During an observation completed on 4/14/25, at 10:05 a.m. the following items were observed on Resident R69's bedside stand: 1 bottle iodine solution. 3 rolls of medical tape.	F 0761		

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F 0761 SS=D	Continued from page 155 1 jar Silvadene cream. 2 bottles saline solution. 1 pair of scissors. During an interview completed on 4/14/25, at 10:09 a.m. Registered Nurse Employee E16 confirmed the above observations and removed items from the room and confirmed the facility failed to secure treatment medications. During an observation completed on 4/14/25, at 12:19 p.m. the second west medication cart contained the following: 1 vial fluphenazine decanoate opened and without a date. 1 box lidocaine patches 1 jar Silvadene cream 1 Lantus insulin vial opened and not labeled with a date. 1 bottle amantadine opened and not labeled with a date. 1 bottle peridex rinse opened and not labeled with a date.	F 0761		

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F 0761 SS=D	Continued from page 156 During an interview completed on 4/14/25, at 12:46 p.m. Registered Nurse Employee E14 confirmed the above observations. During an observation on 4/15/25 at 10:03 a.m. of the second-floor medication room the following was discovered: Under sink the sink a drug disposal container and clear plastic bag. The refrigerator contained: 1 10ml bottle of sterile water opened without date. 1 2mg bottle of cathflo (a sterile solution used to restore function to a central venous access device) opened and without date. 1 envelope containing cash money. On the floor in the corner across from the refrigerator a gray plastic bag containing four pairs of shoes. During an interview completed on 4/15/25, at 10:18 a.m. Registered Nurse (RN) Employee E14 confirmed the above observations and that the	F 0761		

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F 0761 SS=D	Continued from page 157 facility failed to properly store medical supplies and biologicals in one of two medication rooms (second floor medication room) and two of four medication carts (second floor west medication cart). During an observation on 4/17/25, at 9:35 a.m. the first-floor west medication cart contained the following: 1 bottle Miralax bottle opened and not labeled with a date. 1 bottle timolol eye drops no name, opened and not labeled with a date. 1 bottle Ammonium Lactate 12% opened and not labeled with a date. 1 bottle Geri -Lanta opened and not labeled with a date. 1 bottle lactulose solution opened and not labeled with a date. 2 bottles Fluphenazine Hydrochloride opened and not labeled with a date. 1 vial Lantus insulin opened and not labeled with a date. 1 tube mupirocin ointment.	F 0761		

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F 0761 SS=D	Continued from page 158 1 tube arthritis's relief cream. 1 tube triamcinolone cream. 2 boxes lidocaine patches 1 tube diclofenac sodium tube 1 can spring edition red bull beverage. During an interview completed on 4/17/25, at 9:43 a.m. Licensed Practical Nurse (LPN) Employee E15 confirmed the above observations and stated upon seeing the red bull beverage "I would guess it is a staff members, I can't imagine a resident would drink it" and confirmed that the facility failed to properly store medical supplies and biologicals in two of four medication carts (first floor west medication cart) 28 Pa. Code: 211.9(a)(1)(k) Pharmacy services. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0761		

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F 0761 SS=D	Continued from page 159	F 0761		
F 0809 SS=E	483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by:	F 0809	1. Meal times will be adjusted meet the requirements of the 14 hour rule. 2. NHA/designee to educate Dietary Manager on 14 hour rule requirement, and if meal times were to exceed 14 hours, then the presence of a substantial snack is required. 3. Dietary Manager/designee to educate dietary staff on 14 hour rule requirement, and if meal times were to exceed 14 hours, then the presence of a substantial snack is required. 4. Dietary Manager/designee to audit meal times and snacks for all 3 meals 3x/week for 3 weeks, and 1x/week for 3 weeks thereafter. 5. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/22/2025**

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	395666	A. BLDG: __00_____ B. WING: _____	04/18/2025

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

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F 0809 SS=E	Continued from page 160 Based on review of facility policy, facility scheduled mealtimes, resident council group interview, and staff interviews it was determined that the facility failed to ensure the provision of a nourishing (satisfying to the resident) evening snack when greater than 14 hours elapsed from the supper meal to breakfast the next day for residents including three of three residents sampled (Residents R73, R377, and R378), and failed to garner resident group acceptance of a meal span of greater than 14 hours. Findings include: A review of facility policy "Offering/Serving Bedtime Snacks", dated 12/9/24, indicates that it is the practice of the facility to offer and serve residents with a nourishing snack in accordance with their needs, preferences and requests at bedtime on a daily basis. The nursing staff offers bedtime snacks to all residents in accordance with the resident's needs, preference and requests on a daily basis. Intake of bedtime snack is documented in the	F 0809		

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F 0809 SS=E	Continued from page 161 medical record. A review of facility's Meal Times Dietary schedule provided revealed greater than 14 hours between dinner and breakfast: Dinner start time: 4:30 p.m.; Breakfast start time: 8:00 a.m., for a total 15.5 hours. - Dinner Cart 1 (first cart) arrives on unit at 4:45 p.m., Breakfast Cart 1 arrives on unit 8:15 a.m., for a total of 15.5 hours. - Dinner Cart 5 arrives (last cart) arrives on unit at 5:25 p.m., Breakfast Cart 5 arrives on unit at 8:55 a.m., for a total of 15.5 hours. During an interview on 4/15/25, at 11:00 a.m. two of six residents stated they infrequently were provided snacks. During an interview on 4/17/25, at 1:32 p.m., Dietary Manager Employee E11 confirmed that more than 14 hours elapse from the supper meal to breakfast the next day per the facility's scheduled mealtimes.	F 0809		

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F 0809 SS=E	Continued from page 162 During an interview on 4/15/25, at 2:47 p.m., the Nursing Home Administrator (NHA) confirmed that evening snacks are not documented unless a physician order has been placed in the EMR (Electronic Medical Record). Review of the admission record indicated Resident R73 was admitted to the facility on 2/25/25. Review of Resident R73's Minimum Data Set (MDS- a periodic assessment of care needs) dated 3/4/25, indicated diagnoses of high blood pressure, diabetes mellitus (endocrine disease characterized by sustained high blood glucose levels), and osteomyelitis (an infection in the bone) of right ankle and foot. Review of R73's current physician orders failed to reveal an order for offering or providing an evening snack. Review of Resident R73's clinical record failed to	F 0809		

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F 0809 SS=E	Continued from page 163 indicate documentation that a nourishing evening snack was offered or provided. Review of the admission record indicated Resident R377 was admitted to the facility on 4/2/25, with diagnoses that included diabetes mellitus, dysphagia (difficulty swallowing foods, liquids, or both), and muscle weakness. Review of R377's current physician orders failed to reveal an order for offering or providing an evening snack. Review of Resident R377's clinical record failed to indicate documentation that a nourishing evening snack was offered or provided. Review of the admission record indicated Resident R378 was admitted to the facility on 4/2/25, with diagnoses that included cognitive social or emotional deficit following cerebral infarction (stroke related impairments leading to cognitive, social, and emotional deficits. These deficits can significant	F 0809		

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F 0809 SS=E	Continued from page 164 impact an individual's quality of life and their ability to function in daily activities), pulmonary disease, and dementia (group of symptoms affecting memory, thinking and social abilities). Review of R378's current physician orders failed to reveal an order for offering or providing an evening snack. Review of Resident R378's clinical record failed to indicate documentation that a nourishing evening snack was offered or provided. During a review of facility provided Resident Council Minutes since December 2024, failed to indicate resident group acceptance of a meal span greater than 14 hours. During an interview on 4/15/25, at 2:47 p.m., the Nursing Home Administrator (NHA) confirmed that the facility failed to ensure the provision of a nourishing (satisfying to the resident) evening snack when greater than 14 hours elapsed from the supper	F 0809		

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F 0809 SS=E	Continued from page 165 meal to breakfast the next day for residents including three of three residents sampled (Residents R73, R377, and R378), and failed to garner resident group acceptance of a meal span of greater than 14 hours. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(3) Nursing Services 28 Pa. Code 211.12(d)(5) Nursing Services 28 Pa. Code: 201.18(b)(1) Management. **28 Pa. Code 201.18(b)(3) Management**	F 0809		
F 0825 SS=E		F 0825		

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 0825 SS=E	Continued from page 166 483.65(a)(1)(2) Provide/Obtain Specialized Rehab Services §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by:	F 0825	1. Residents experienced no adverse effects, and R127 and R278 will receive therapy services as ordered. 2. Whole house audit to be completed on physiatry consults and specialized rehabilitative services. 3. Resident R16 has since been consulted by physiatry and physical therapist is working with organization for prosthetic process. 4. DOR/designee to educate nursing staff and therapy staff on physiatry consults and specialized rehabilitative services. 5. DOR/designee to audit orders for physiatry consults and therapy consults 3x/week for 2 weeks, 2x/week for 2 weeks, and 1x/week for 2 weeks. 6. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/22/2025**

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F 0825 SS=E	Continued from page 167 Based on a review of facility documents, and resident and staff interview, it was determined that the facility failed to provide specialized rehabilitative services for three of three residents (Resident R16 and R237). Findings Include: Review of the facility policy "Therapy Evaluation" dated 12/9/24, stated the licensed therapist will perform an initial resident evaluation upon physician referral and any reevaluation where indicated. The Rehabilitation Department will be notified when a physician order is written for therapy evaluation and treatment. Review of the facility policy "Therapy Treatment Procedures for Therapeutic Exercise" dated 12/9/25, stated it is the facility's policy to provide therapy treatment procedures for therapeutic exercise as necessary. Review of the clinical record revealed that Resident	F 0825		

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F 0825 SS=E	Continued from page 168 R16 was admitted to the facility on 1/2/25. Review of Resident R16's care plan dated 1/2/25, indicated for therapy to evaluate and treat as ordered and as needed. Review of Resident R16's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 1/7/25, indicated diagnoses of right below the knee amputation, diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces), and peripheral vascular disease (a slow and progressive disease that impacts the blood vessels in the body outside the heart.) Review of Resident R16's clinical record revealed occupational and physical therapy began on 1/7/25, with a frequency of 5x/week. Review of Resident R16's therapy discharge summary dated 1/23/25, indicated the resident continues at long term care pending housing and	F 0825		

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F 0825 SS=E	Continued from page 169 prothesis. Review of Resident R16's active physician order dated 3/1/25, indicated to consult physiatry for prosthetic. During an interview on 4/14/25, at 2:23 p.m. Resident R16 stated I need a stump shrinker, I still don't have one. Review of Resident R16's clinical record on 4/17, 25, at 10:00 a.m. failed to include evidence the facility consulted physiatry for prosthetic as ordered. During an interview on 4/17/25, at 10:45 a.m. Physical Therapist, Employee E32 was asked what is the status of Resident R16 receiving a prosthetic and stated "I am happy you are looking into it. I was just made aware two days ago, I am unsure how to obtain, told resident to call physician, it was indicated the physician did not want to talk to the resident." PT, Employee E32 was not aware how to obtain Resident R16's prosthetic.	F 0825		

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F 0825 SS=E	Continued from page 170 Review of the clinical record indicated Resident R278 was admitted to the facility on 4/1/25. Review of Resident R278's physician order dated 4/1/25, for physical therapy screen, evaluate, and treat as indicated. Review of Resident R278's care plan dated 4/1/25, indicated to complete therapy as ordered. Review of Resident R278's physician note dated 4/3/25, indicated the resident had a below the knee amputation on 3/18/25, and is working with therapy to work toward shrinker and prosthetic. Review of Resident R278's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/7/25, indicated diagnoses of Post Traumatic Stress Disorder (PTSD- a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event), acquired absence of right leg below knee, and	F 0825		

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F 0825 SS=E	Continued from page 171 insomnia (difficulty staying or falling asleep). Review of Resident R278's clinical record revealed physical therapy began on 4/8/25, seven days after admission. During an interview on 4/14/25, at 9:55 a.m. Resident R278 stated I came here for therapy and there was a delay in starting it. During an interview on 4/17/25, at 1:43 p.m. Director of Rehab, Employee E33 confirmed the facility failed to evaluate and treat Resident R16 timely. During an interview on 4/17/25, at 1:58 p.m. Director of Rehab, Employee E33 stated as far as i know, there hasn't been anything in process for Resident R278's stump shrinker. During an interview on 4/17/25, at 3:17 p.m. the Nursing Home Administrator and DON confirmed the facility failed to provide specialized rehabilitative	F 0825		

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F 0825 SS=E	Continued from page 172 services for three of three residents (Resident R16 R127, and R278). 28 Pa Code: 201.18(e)(1) Management. 28 Pa. Code: 211.10(c)(d) Resident care policies.	F 0825		
F 0850 SS=E	483.70(o)(1)(2) Qualifications of Social Worker >120 Beds §483.70(o) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is: §483.70(o)(1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and	F 0850	1. Facility hired a FT social worker. 2. NHA will receive education from Vice President of Operations on requirement for a full time Social Worker. 3. NHA/designee will audit role x3 months to ensure facility meets requirements. 4. Results of audits will be submitted to QAPI committee for further recommendation.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/22/2025**

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F 0850 SS=E	Continued from page 173 §483.70(o)(2) One year of supervised social work experience in a health care setting working directly with individuals. This REQUIREMENT is not met as evidenced by:	F 0850		

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F 0850 SS=E	Continued from page 174 Based on review of clinical records and staff interview it was determined that the facility failed to employ a full time social worker. Findings include: Review of clinical records for Resident R16, and Resident R128, Resident R278 clinical records indicated the NHA was completing social service documentation. During an interview on 4/17/25, at 3:28 p.m. confirmed that the facility did not have a fulltime social worker, and that the NHA has been filling in for the social worker. The facility has been without a social for approximately a month and that the facility failed to employ a full tie social worker to meet residents psychosocial needs. Refer to F699, F740, and F745. 28 Pa.Code: 211.16. (a) Social services.	F 0850		

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F 0868 SS=E	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 of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.	F 0868	1. Facility has since had an Infection Preventionist to attend next QAPI meeting. 2. NHA will receive education from Vice President of Operations on QAPI attendees. 3. NHA will educate all required attendees of QAPI-on-QAPI attendance requirements. 4. NHA to audit QAPI attendees for all required attendees for 2 quarters. 5. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/19/2025**

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: _____	04/18/2025

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F 0868 SS=E	Continued from page 176 This REQUIREMENT is not met as evidenced by:	F 0868		

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F 0868 SS=E	Continued from page 177 Based on review of facility policy, 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 of the required committee members for three of four quarters (April 2024 through June 2024 and July 2024 through December 2024). Findings include: Review of facility policy "Quality Assessment and Assurance Committee" last reviewed 12/9/24, indicated the facility will maintain a QAA Committee to identify quality issues and develop appropriate plans of action to correct quality deficiencies through an interdisciplinary approach. The committee will be composed of the following staff at a minimum. -Director of Nursing -Medical Director or his/her designees -The Infection Preventionist -At least three other facility staff members, one of which will be the Administrator, owner, a board	F 0868		

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F 0868 SS=E	Continued from page 178 member, or other individual in a leadership role. The facility failed to have the QAPI Committee meeting sign-in sheets from the period of April 2024 through June 2024 available for review. A review of the QAPI Committee meeting sign-in sheets from the period of July 2024 through December 2024, did not reveal that the Infection Preventionist was in attendance. During an interview on 4/18/25, at 12:32 p.m. the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to conduct QAA meetings at least quarterly with all of the required committee members as required. 28 Pa Code: 201.18(e)(1)(2) Management.	F 0868		
F 0880 SS=E		F 0880		

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F 0880 SS=E	Continued from page 179 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	1. Residents and staff had no negative effects related to Enhanced Barrier Precautions and Infection Control surveillance. 2. DON/designee to educate Infection Control nurse and licensed staff on Enhanced Barrier Precautions, cross contamination during dressing changes, and surveillance tracking. 3. DON/designee to educate all staff on Enhanced Barrier Precautions and Infection Control and Prevention surveillance. 4. DON/designee to audit Enhanced Barrier Precautions and what residents require EBP, EBP observations on use of proper precautions/attire, dressing changes observations to ensure no cross-contamination and review of infection control surveillance for thoroughness 1x/week for 4 weeks, then monthly x 2 months. 5. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/22/2025**

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F 0880 SS=E	Continued from page 180 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=E	Continued from page 181	F 0880		

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F 0880 SS=E	Continued from page 182 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to follow enhanced barrier precautions for two of five residents (Resident R13 and R68), failed to prevent cross contamination during a dressing change for one of three residents (Resident R68), and failed to implement an infection control program that included a system of surveillance that included tracking, trending and mapping to identify possible communicable diseases or infections for one of six months (January 2025). Findings include: Review of the facility policy "Dressings, Dry/Clean", last reviewed 12/9/24, indicates the purpose of this procedure is to provide guidelines for the application of dry, clean dressings. Steps in the procedure include but are not inclusive to: -Clean bedside stand. Establish a clean field. -Place the equipment on the clean field -Tape a biohazard or plastic bag on the bedside stand or use a waste basket below clean field	F 0880		

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F 0880 SS=E	Continued from page 183 -Wash and dry hands -Put on clean gloves -Cleanse wound -Discard items -Remove gloves, wash and dry hands -Apply the ordered dressing -Remove gloves, wash and dry hands -Clean bedside stand -Wash and dry hands Review of the facility policy "Handwashing/Hand hygiene", last reviewed 12/9/24, indicates this facility considers hand hygiene the primary means to prevent the spread of infection. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection. Review of facility policy "Care and Treatment of Feeding tubes last reviewed 12/9/24, indicates to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complication to the extent possible use infection control precautions and related techniques	F 0880		

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F 0880 SS=E	Continued from page 184 to minimize the risk of contamination. Review of the facility policy "Isolation-Categories of Transmission Based Precautions" last reviewed 12/9/24, indicates enhanced barrier precautions (EBP's) are utilized to prevent the spread of multi-drug-resistant organism (MDROs). EBP's are in place for residents with wounds and indwelling medical devices. EBP's remain in place for the duration of the residents stay. Review of Center for Disease (CDC) definition for Enhanced Barrier Precautions (EBP, a type of special isolation when providing direct care to a resident): The use of isolation gown and gloves during high-contact resident care activities including wound care. Review of the facility policy "Infection Prevention and Control Program" last reviewed 12/9/24, indicates a system of surveillance is utilized for prevention, identifying, reporting, investigation, and controlling infections for all residents, staff,	F 0880		

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F 0880 SS=E	Continued from page 185 volunteers, visitors and other individuals providing service. COVID-19 Testing: Anyone with even mild symptoms of COVID 19 should receive a test as soon as possible. Testing is recommended typically on day 1, day 3, and day 5 (day of exposure is day 0). The facility will have a plan to investigate and manage how contact tracing will be performed. Review of the facility policy "Norovirus Prevention and Control", last reviewed 12/9/24, indicates the facility will implement strict infection control measures to prevent the transmission of the norovirus infection. Approaches for cohorting residents during the outbreak may include placing the resident in multi-occupancy rooms, or designated resident care areas or contiguous sections in the facility. Review of the facility policy "Outbreak of Communicable Disease" last reviewed 12/9/24, indicates outbreaks of communicable diseases within the facility will be promptly identified and appropriately handled. The Infection Preventionist	F 0880		

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F 0880 SS=E	Continued from page 186 (IP) and Director of Nursing (DON) shall be responsible for including but not inclusive to: Receiving surveillance information and tabulating data, maintaining a line list of identified cases and tracking. Review of Resident R13's clinical record indicates an admission date of 9/4/24. Review of Resident 13's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/4/25, indicates the diagnosis of heart failure (heart can't pump the way it should), hypertension (high blood pressure), and diabetes (high sugar in the blood) Review of Resident R13's physician orders dated 4/8/25, revealed the resident was ordered Enhanced Barrier Precautions (EBP). Review of Resident R13's physician orders dated 1/10/25, indicated Tylenol Extra Strength Oral Tablet 500 milligrams (MG) Give 2 tablet via	F 0880		

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F 0880 SS=E	Continued from page 187 G-Tube (a flexible tube placed into the stomach to deliver nutrition or medication) three times a day for pain/discomfort. During a medication administration observation completed on 4/15/25, at 1:10 p.m. Registered Nurse (RN) Employee E13 entered resident R13's room. RN Employee E13 administered Resident R13's Tylenol as ordered. RN employee E13 did not utilize a gown as indicated by EBP signage on the door. During an interview completed on 4/15/25 at 1:13 p.m. RN Employee E13 confirmed not utilizing a gown during the medication administration via g-tube as required. Review of Resident R68's clinical record indicates an admission date of 9/26/24. Review of Resident R68's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/31/25, indicates the diagnosis of anemia (low iron	F 0880		

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F 0880 SS=E	Continued from page 188 in the blood), hypertension (high blood pressure) and diabetes (high sugar in the blood). Review of Resident R68's physician orders dated 3/26/25, indicates wound: cleanse left dorsal foot with Normal Saline Solution (NSS), pat dry, apply Medi honey to wound bed, apply oil emulsion dressing, cover with foam border dressing daily and as needed. Review of Resident R68's physician orders dated 4/6/25, indicate Enhanced Barrier precautions (EBP) related to due to wounds every shift. During an observation on 4/17/25, at 11:05 a.m. RN Employee E31 entered Resident R68's room to complete a dressing change. EBP signage was posted on the resident's door entrance. RN Employee E31 did not utilize a gown as indicated. RN Employee E31 placed the dressing supplies on the bed and applied gloves. Resident R68 requested a pad/barrier to be placed under her foot. RN employee E31 did not bring a barrier into the room,	F 0880		

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F 0880 SS=E	Continued from page 189 Resident R68 handed her a washcloth that was placed under her left foot. RN employee E31 the placed three paper towels on top of the washcloth and placed the heel of the left foot onto the paper towels. RN Employee E31 removed the soiled dressing, placing it into her glove, used another glove as a waste bag and placed onto the bed. Observation of wound revealed a piece of oil emulsion remained on the top surface of the wound. Resident R68 stated a package of the oil emulsion was in her bedside stand. RN Employee E31 retrieved the opened undated package and cut a small square, she removed her gloves and applied new gloves. RN Employee E31 placed the oil emulsion on top of the wound and applied the Medi honey on top of the oil emulsion by squeezing it directly from the tube, removed her gloves and placed new gloves prior to covering the area with a clean dressing. RN Employee E31 removed the paper towels that were under Resident R68's foot exited the room with the soiled supplies and placed all into the trash receptacle on the side of the treatment cart. She removed her gloves and	F 0880		

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F 0880 SS=E	Continued from page 190 indicated the treatment was completed. During an interview completed on 4/17/25, at 11:26 a.m. RN Employee E31 confirmed not establishing a clean field prior to dressing change, numerous opportunities for hand hygiene were missed. Utilizing undated opened treatment supplies from the bedside stand, dispensing the Medi honey directly onto the wound from the tube, utilizing a glove for her soiled discards and not following enhanced barrier precautions during the dressing change as required. Review of the facility provided Gastrointestinal complaints/Norovirus time line on 4/17/25, indicated that in January of 2025, 27 residents were noted to have had GI complaints. Review of the infection control tracking facility mapping for January 2025, did not include residents who were diagnosed with norovirus. During an interview completed on 4/17/25, at 1:56 p.m. Infection Preventionist (IP) RN Employee E18	F 0880		

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F 0880 SS=E	Continued from page 191 confirmed that the residents who were diagnosed with the GI/norovirus in January of 2025, were not included on the infection control mapping. Upon further query IP RN Employee E18 also stated the facility has not kept tract of the residents or employees with signs or symptoms of COVID 19. Upon asking IP RN Employee E18 the process for Covid testing if indicated, she stated we would complete a test if negative no further testing would be needed, she was unable to provide information on testing guidelines and stated, "we do what the CDC says to do" and further commented "Trump took down all the stuff for the CDC guidance, it went away". During an interview completed on 4/17/25, at 3:17 p.m. the Nursing Home Administrator confirmed that the facility failed to follow enhanced barrier precautions for two of five residents (Resident R13 and R68) failed to prevent cross contamination during a dressing change for one of three residents (Resident R68) and failed to implement an infection control program that included a system of	F 0880		

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:	04/18/2025

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**

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F 0880 SS=E	Continued from page 192 surveillance tracking, trending and mapping to identify possible communicable diseases or infections for one of six months (January 2025). 28 Pa. code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b) (1) (e) (1) Management. 28 Pa. Code: 211.10 (d) Resident care policies. 28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.	F 0880		
F 0882 SS=E		F 0882		

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 0882 SS=E	Continued from page 193 483.80(b)(1)-(4) Infection Preventionist Qualifications/Role §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by:	F 0882	1. Facility has since had a full time Infection Preventionist. 2. NHA will receive education from Vice President of Operations on requirements for Infection Preventionist. 3. DON/designee to audit Infection Preventionist implementing programs and activities to prevent and control infections weekly x 4 weeks, then monthly x 4 months. 4. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/19/2025**

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 0882 SS=E	Continued from page 194 Based on a review of select facility policy and staff interview, it was determined the facility failed to designate a qualified individual(s) onsite, who is responsible for implementing programs and activities to prevent and control infections (Mid-October 2024, to 2/21/25). Findings included: The Centers for Medicare and Medicaid Services regulation §483.80(b)(3) states the facility must designate one or more individuals as the infection preventionist who are responsible for the facility's Infection Prevention and Control Program. The IP (infection preventionist) must work at least part-time at the facility, physically work onsite in the facility, have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field, cannot be an off-site consultant or perform the IP work at a separate location. During an interview on 4/17/25, at 1:56 p.m., the IP, Employee E18 stated, "I can't tell you an exact	F 0882		

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 0882 SS=E	Continued from page 195 start date, I would say sometime in January they combined the wound care position with infection control, the other nurse handed it to the Director of Nursing around mid-October, my certificate date is 2/21/25. During an interview on 4/17/25, at 3:17 p.m. the Nursing Home Administrator and Director of Nursing (DON) confirmed the facility failed to designate a qualified individual(s) onsite, who is responsible for implementing programs and activities to prevent and control infections (Mid-October 2024, to 2/21/25). 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management.	F 0882		

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F 0882 SS=E	Continued from page 196	F 0882		
F 0883 SS=D	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the	F 0883	1. Residents experienced no adverse effects. R13 and R60 will be up-to-date with appropriate vaccinations as requested. 2. DON/designee to educate licensed staff on need to offer and document immunizations timely and appropriately. 3. DON/designee will conduct a whole house audit to ascertain if current residents are up to date on immunizations as appropriate. 4. DON/designee to audit new admissions and hospitals returns daily x 1 week, then 3x/week for 3 weeks, and 1x/week for 2 weeks. 5. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/22/2025**

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 0883 SS=D	Continued from page 197 immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 0883		

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 0883 SS=D	Continued from page 198 Based on facility policy, clinical record review and staff interview, it was determined that the facility failed to provide accurate and timely documentation related to the Influenza and Pneumonia vaccine for two of five residents (Resident R13 and R60). Findings include: Review of facility policy "Influenza, Prevention and Control of Seasonal" last reviewed 12/9/24, indicates this facility follows current guidelines and recommendations for the prevention and control of seasonal influenza. All residents and staff are offered the vaccine prior to the onset of the influenza season. Review of the facility policy "Pneumococcal Vaccine" last reviewed 12/9/24, indicates all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series and when indicated	F 0883		

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F 0883 SS=D	Continued from page 199 will be offered the vaccine series within thirty days of admission to the facility unless medically contraindicated or the resident had already been vaccinated. Review of Resident R13's clinical record indicated the resident was admitted to the facility on 9/4/24. Review of Resident R13's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/4/25, indicated diagnoses of high blood pressure, heart failure (heart doesn't pump the way it should) and chronic obstructive pulmonary disease (COPD-difficulty in breathing) MDS Section O-Special treatment, Procedures, and Programs O0250 indicated Influenza vaccine was coded "9"-none of the above. O0300 indicated Pneumonia vaccine was coded a dash "-". During a review of Resident R13's clinical record on 4/14/25, indicated that the Influenza and Pneumonia vaccination was not entered and was blank.	F 0883		

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F 0883 SS=D	Continued from page 200 Review of Resident R60's clinical record indicated the resident was admitted to the facility on 2/5/24. Review of Resident R60's MDS dated 2/20/25, indicated the diagnosis of anemia (low iron in the blood), coronary artery disease (CAD- buildup of plaque in the hearts arteries) and anxiety. MDS Section O- Special treatment, Procedures, and Programs O0250 indicated Influenza vaccine was coded "0"- no reason "4"-offered and declined. O0300 indicated Pneumonia vaccine was coded a "0"- no reason "3"-not offered. During a review of Resident R60's clinical record on 4/14/25, indicated that the Influenza and Pneumonia vaccination was not entered and was blank. During an interview completed on 4/17/25, at 1:56 p.m. upon asking Infection Preventionist (IP) Employee E18 the facility procedure for the influenza vaccine she replied "I did not participate in it" Upon inquiry concerning pneumococcal vaccine IP Employee E18 stated " we don't try to get every	F 0883		

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F 0883 SS=D	Continued from page 201 immunization they missed" further query concerning the immunizations for residents in the facility, IP Employee E18 replied "we don ' t really have a process, we don ' t document of the refusal for immunizations" and confirmed that the facility failed to provide accurate and timely documentation related to the Influenza and Pneumonia vaccine for two of five residents (Resident 13 and R60). 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(3) Nursing services.	F 0883		
F 0908 SS=D		F 0908		

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F 0908 SS=D	Continued from page 202 483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by:	F 0908	1.Residents or staff did not experience any adverse effects from 3 out of 6 steam wells in the steam table and one dryer being down. 2.NHA/designee to educate Plant Operations Manager and Dietary Manager on the need to maintain essential equipment. 3.Maintenance Director/designee will gather quotes for equipment in question in order for repairs to be made. Facility will move forward with approved repair based on vendor/part availability 4.Plant Operations Manager/designee to audit these two pieces of equipment for function 3x/week for 2 weeks, 1x/week for 2 weeks, and monthly x3 months thereafter. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/28/2025**

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 0908 SS=D	Continued from page 203 Based on observations and staff interviews, it was determined that the facility failed to make certain that equipment was in safe operating condition in the main kitchen and the facility failed to maintain essential equipment with a dryer not working (1 of 2 dryers). Findings include: Review of Code of Federal Regulations §483.90(d) (2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. During an observation on 4/17/25, at 12:35 p.m., it was revealed that the main kitchens six well steam table (a type of commercial food service equipment that is used to keep foods at optimal serving temperatures) was operating with only three steam wells. During an interview on 4/17/25, at 1:32 p.m., Dietary Manager (DM) Employee E11 confirmed that only three of six steam table wells are	F 0908		

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 0908 SS=D	Continued from page 204 functioning time of interview. Further interview revealed that DM Employee E11 was hired in December 2024, and at that time, 2 steam wells were broke and not functioning. DM Employee E11 stated that the third steam well just broke within the last few weeks. During an interview on 4/17/25, at 1:35 p.m., Dietary Cook Employee E12 revealed that he was hired nine months ago, and at that time 2 steam wells were broken and not functioning. Employee E12 stated that the third steam well just broke within the last month, and that back in October 2024, Maintenance was made aware of malfunctioning steam table, and service call from an outside food service equipment repair vendor was completed. Employee E12 stated that the vendor identified equipment parts needed to be ordered and replaced in order to fix the 2 broken wells. During an interview on 4/17/25, at 2:30 p.m., Maintenance Director (MD) Employee E13 confirmed that an outside food service equipment	F 0908		

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F 0908 SS=D	Continued from page 205 vendor came in and looked at the broken steam table wells in October 2024, and provided the facility with an invoice identifying parts needed and cost to repair. MD Employee E13 stated that this invoice for repair was provided to administration for payment. During an interview on 4/18/25, at 11:45 a.m., the Nursing Home Administrator (NHA) confirmed that the facility failed to make certain that equipment was in safe operating condition in the main kitchen. During an observation on 4/16/25, at 11:31 a.m. one dryer was not working and the other dryer was in use in the laundry room. During an interview on 4/16/25, at 11:35 a.m. Laundry Assistant Employee E34 Stated the dryer is down, so we only have one dryer. During an interview on 4/17/25, 10:10 a.m. Director of Maintenance Employee E16 confirmed that the facility has a dryer down and the facility failed to	F 0908		

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F 0908 SS=D	Continued from page 206 maintain essential equipment. 28 Pa Code: 201.14(a) Responsibility of licensee.	F 0908		
F 0943 SS=D	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	1. No residents experienced adverse effects by failing to provide pre-employment abuse training. E3 will have education. 2. Abuse training will be provided during the pre-employment orientation program. 3. NHA/designee to re-educate current employees on the Abuse, Neglect, and Exploitation Policy. 4. NHA/designee to audit new employee orientation folders 1x/week for 4 weeks, then monthly x 2 months. 5. Results to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/22/2025**

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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 0943 SS=D	Continued from page 207	F 0943		

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: _____	04/18/2025

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F 0943 SS=D	Continued from page 208 Based on review of facility policy, employee personnel records, and staff interview, it was determined that the facility failed to provide training on Abuse, Neglect, and Exploitation on the date of orientation for one out of five sampled records (Physical Therapist Employee E3). Findings include: The facility "Abuse, neglect, and misappropriation education" policy reviewed 12/9/24, indicated to abuse, neglect, and misappropriation of resident funds education is completed upon hire and at least annually for all employees. Review of Physical Therapist Employee E3 personnel record indicated she was hired on 3/31/25. Facility punch detail report (Report indicating which days staff worked) dated 4/17/25, indicated that Physical Therapist Employee E3 worked at the facility for five days in April of 2025. Review of Physical Therapist Employee E3	F 0943		

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F 0943 SS=D	Continued from page 209 personnel record did not include abuse training during her orientation to the facility. During an interview on 4/17/25, at 12:34 p.m. the Human Resources Employee E5 confirmed that the facility failed to provide training on Abuse, Neglect, and Exploitation on the date of orientation for Physical Therapist Employee E3 as required. 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		

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P 1020	Responsibility of licensee. (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other Federal, State and local agencies responsible for the health and welfare of residents. This includes complying with all applicable Federal and State laws, and rules, regulations and orders issued by the Department and other Federal, State or local agencies. This REGULATION is not met as evidenced by:	P 1020	1. Facility will have required attendees for quarterly Infection Control meetings. 2. NHA to educate DON/designee of required Infection Control attendees. 3. DON/designee to educate all required attendees and attendance requirements. 4. DON/designee to audit Infection Control meeting required attendees and notification to resident/resident representative of acquired healthcare associated infections while at the facility monthly x 6 months.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/19/2025**

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 1020	Continued from page 1 Based on staff interview and review of the facility's Infection Control Committee attendance records, the facility failed to ensure that the nine required multidisciplinary members were present at the Infection Control meetings (community member and patient safety officer) for four of four quarters (Quarters Two, Three and Four of 2024, and Quarter One of 2025) and failed to ensure that Infection Control Committee meetings occurred for six of twelve months (October, November and December of 2024 and January, February and March of 2025). Findings include: Review of Act 52 (The Act of March 20, 2002, P.L. 154, No. 13), known as the Medical Care Availability and Reduction of Error (MCARE) Act, Chapter 4, Section 403(1) Infection Control plan states, "A health care facility... shall develop and implement an internal infection control plan that shall include... a multidisciplinary committee including representatives from each of the following if	P 1020		

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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

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P 1020	Continued from page 2 applicable to that specific health care facility." A review of the applicable members at infection control meetings includes medical staff, administration, laboratory personnel, nursing staff, pharmacy staff, physical plan personnel, patient safety officer, a community member, and a member of the infection control team. Review of the facility's Infection Control Committee Attendance Log indicated that the nine required multidisciplinary members were not present at the Infection Control meetings (community member and patient safety officer) for four of four quarters (Quarters Two, Three and Four of 2024, and Quarter One of 2025)and the Infection Control Committee meetings did not occurred for six of twelve months (October, November and December of 2024 and January, February and March of 2025). During an interview completed on 04/17/25, at 12:29 p.m. the Infection Preventionist RN Employee E18 confirmed that that the nine required	P 1020		

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P 1020	Continued from page 3 multidisciplinary members were not present at the Infection Control meetings (community member and patient safety officer) for four of four quarters (Quarters Two, Three and Four of 2024, and Quarter One of 2025)and the Infection Control Committee meetings did not occurred for six of twelve months (October, November and December of 2024 and January, February and March of 2025). During an interview completed on 4/17/25, at 3:17 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure that the nine required multidisciplinary members were present at the Infection Control meetings (community member and patient safety officer) for four of four quarters (Quarters Two, Three and Four of 2024, and Quarter One of 2025) and failed to ensure that Infection Control Committee meetings occurred for six of twelve months (October, November and December of 2024, and January, February, and March of 2025).	P 1020		

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P 1470	Personnel policies and procedures. (4) A determination by a health care practitioner that the employee, as of the employee's start date, is free from the communicable diseases or conditions listed in § 27.155 (relating to restrictions on health care practitioners). This REGULATION is not met as evidenced by:	P 1470	1. No residents experienced adverse effects. Housekeeping Staff Employee E1, Physical Therapist Employee E3, and Nurse Aide Employee E4 will have their physical completed. 2. Physical assessment signed by a provider will be required during the pre-employment process to determine that staff are free from communicable diseases. 3. NHA to educate HR Director/designee on need for physical assessment signed by a provider during the pre-employment process to determine that staff are free from communicable diseases. 4. HR Director/designee to audit new employee orientation folders 1x/week for 4 weeks, then monthly x 2 months.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/22/2025**

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P 1470	Continued from page 5 Based on a review of facility policy, personnel records, and staff interview, it was determined that the facility failed to ensure that a health care practitioner determined that newly hired employees were free from communicable disease for three out of five personnel records (Housekeeping Staff Employee E1, Physical Therapist Employee E3, and Nurse Aide Employee E4). Findings include: The facility "Employee infection and vaccination status" policy reviewed 12/9/24, indicated that prior to or upon an employee's duty assignment, the facility will assess the status of an employee's vaccination against infectious disease, screening for tuberculosis and recent history of communicable disease. Review of Housekeeping Staff Employee E1 personnel record indicated she was hired on 2/13/25. Facility punch detail report (Report	P 1470		

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P 1470	Continued from page 6 indicating which days staff worked) dated 4/17/25, indicated that Housekeeping Staff Employee E1 worked seven days in Feburary, 21 days in March, and 13 days in April of 2025. Review of Physical Therapist Employee E3 personnel record indicated she was hired on 3/31/25. Facility punch detail report dated 4/17/25, indicated that Physical Therapist Employee E3 worked at the facility for five days in April of 2025. Review of Nurse Aide Employee E4 personnel record indicated she was hired on 3/17/25. Facility punch detail report dated 4/17/25, indicated that Nurse Aide Employee E4 worked at the facility for eight days in March and 14 days in April 2025. Review of personnel records for Housekeeping Staff Employee E1, Physical Therapist Employee E3, and Nurse Aide Employee E4 found no documented evidence that a health care practitioner assessed each person and determined that they were free from communicable disease prior to	P 1470		

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P 1470	Continued from page 7 employment. During an interview on 4/17/25, at 12:34 p.m. the Human Resources Employee E5 confirmed that the facility failed to ensure that a health care practitioner determined that newly hired employees were free from communicable disease for Housekeeping Staff Employee E1, Physical Therapist Employee E3, and Nurse Aide Employee E4 as required.	P 1470		
P 1700		P 1700		

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P 1700	Continued from page 8 Prevention, control and surveillance of tuber (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. This REGULATION is not met as evidenced by:	P 1700	1. No residents experienced adverse effects. Housekeeping Staff Employee E1, Occupational Therapist Employee E2, and Physical Therapist Employee E3 will have their TB testing completed. 2. Two-step TB test administered and signed by licensed nursing staff will be required during the pre-employment process to determine that staff are free from communicable diseases. 3. NHA to educate HR Director/designee on need for two-step TB test administered and signed by licensed nursing staff during the pre-employment process to determine that staff are free from communicable diseases. 4. HR Director/designee to audit new employee orientation folders 1x/week for 4 weeks, then monthly x 2 months.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/22/2025**

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P 1700	Continued from page 9 Based on review of facility policy, personnel records, and staff interview, it was determined that the facility failed to implement pre-employment screening procedures for Tuberculosis (TB) for three out of five newly hired personnel record (Housekeeping Staff Employee E1, Occupational Therapist Employee E2, and Physical Therapist Employee E3). Findings include: The facility "Tuberculosis, Employee screening" policy reviewed 12/9/24, indicated that all employees are screened for latent tuberculosis infection and active tuberculosis disease using a tuberculosis skin test or interferon gamma release test and symptom screening prior to employment. Each newly hired employee is screened after an employment offer has been made prior to the employee's assignment. Review of Housekeeping Staff Employee E1	P 1700		

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P 1700	Continued from page 10 personnel record indicated she was hired on 2/13/25. Facility punch detail report (Report indicating which days staff worked) dated 4/17/25, indicated that Housekeeping Staff Employee E1 worked seven days in Feburary, 21 days in March, and 13 days in April of 2025. Review of Occupational Therapist Employee E2 personnel record indicated he was hired on 3/3/25. Facility punch detail report dated 4/17/25, indicated that Occupational Therapist Employee E2 worked at the facility for seven days in March and five days in April 2025. Review of Physical Therapist Employee E3 personnel record indicated she was hired on 3/31/25. Facility punch detail report dated 4/17/25, indicated that Physical Therapist Employee E3 worked at the facility for five days in April of 2025. Review of Housekeeping Staff Employee E1, Occupational Therapist Employee E2, and Physical Therapist Employee E3 personnel records did not	P 1700		

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P 1700	Continued from page 11 include pre-employment screenings using either a tuberculosis skin test or interferon gamma release test per Center for Disease Control (CDC) guidelines. During an interview on 4/17/25, at 12:34 p.m. the Human Resources Employee E5 confirmed that the facility failed to implement Tuberculosis pre-employment screening procedures for Housekeeping Staff Employee E1, Occupational Therapist Employee E2, and Physical Therapist Employee E3.	P 1700		
P 5530		P 5530		

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P 5530	Continued from page 12 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 staffing 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. NHA is implementing recruitment focus meetings. 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 to be submitted to QAPI for review and approval.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **05/22/2025**

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P 5530	Continued from page 13 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 licensed practical nurse per 25 residents during the day shift, one licensed practical nurse per 30 residents during the evening shift, and one licensed practical nurse per 40 residents during the night shift on five of 21 days (3/24/25, 3/25/25, 3/26/25, 3/29/25, and 4/11/25). Findings include: Review of facility census data indicated that on 3/24/25, the facility census was 70, which required three licensed practical nurses (LPNs) during the day shift (equivalent of 21.00 hours of LPN care). Review of nursing time schedules revealed 15.90 hours of LPN care was provided. No additional excess higher level staff were available to compensate this deficiency. Review of facility census data indicated that on 3/24/25, the facility census was 70, which required	P 5530		

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SPRING HILL REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **192902**	**2170 RHINE STREET PITTSBURGH, PA 15212**

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P 5530	Continued from page 14 two LPNs during the night shift (equivalent of 13.13 hours of LPN care). Review of nursing time schedules revealed 8.50 hours of LPN care was provided. No additional excess higher level staff were available to compensate this deficiency. Review of facility census data indicated that on 3/25/25, the facility census was 71, which required three LPNs during the day shift (equivalent of 21.30 hours of LPN care). Review of nursing time schedules revealed 16.22 hours of LPN care was provided. No additional excess higher level staff were available to compensate this deficiency. Review of facility census data indicated that on 3/25/25, the facility census was 71, which required two LPNs during the night shift (equivalent of 13.31 hours of LPN care). Review of nursing time schedules revealed 8.32 hours of LPN care was provided. No additional excess higher level staff were available to compensate this deficiency. Review of facility census data indicated that on	P 5530		

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:	04/18/2025

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**

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P 5530	Continued from page 15 3/26/25, the facility census was 71, which required three LPNs during the day shift (equivalent of 21.30 hours of LPN care). Review of nursing time schedules revealed 16.05 hours of LPN care was provided. No additional excess higher level staff were available to compensate this deficiency. Review of facility census data indicated that on 3/26/25, the facility census was 71, which required two LPNs during the night shift (equivalent of 13.31 hours of LPN care). Review of nursing time schedules revealed 8.05 hours of LPN care was provided. No additional excess higher level staff were available to compensate this deficiency. Review of facility census data indicated that on 3/29/25, the facility census was 73, which required two LPNs during the night shift (equivalent of 13.50 hours of LPN care). Review of nursing time schedules revealed 7.72 hours of LPN care was provided. No additional excess higher level staff were available to compensate this deficiency.	P 5530		

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: _____	04/18/2025

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**

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P 5530	Continued from page 16 Review of facility census data indicated that on 4/11/25, the facility census was 76, which required three LPNs during the evening shift (equivalent of 19.00 hours of LPN care). Review of nursing time schedules revealed 15.30 hours of LPN care was provided. No additional excess higher level staff were available to compensate this deficiency. During an interview on 4/16/25, at 3:12 p.m. the Nursing Home Administrator confirmed the facility failed to provide a minimum of one licensed practical nurse per 25 residents during the dayshift, one licensed practical nurse per 30 residents during the evening shift, and one licensed practical nurse per 40 residents during the night shift on five of 21 days (3/24/25, 3/25/25, 3/26/25, 3/29/25, and 4/11/25).	P 5530		

Certified End Page

SPRING HILL REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 192902

SURVEY EXIT DATE: 04/18/2025

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