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:	05/01/2025

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 an Abbreviated Survey in response to a complaint, completed on May 1, 2025, it was determined that Spring Hill Rehabilitation and Nursing Center was in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities; however, the facility was not in compliance with the 28. Pa Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		

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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H 0009	51.3 (g)(1-14) NOTIFICATION 51.3 Notification (g) For purposes of subsections (e) and (f), events which seriously compromise quality assurance and patient safety include, but not limited to the following: (1) Deaths due to injuries, suicide or unusual circumstances. (2) Deaths due to malnutrition, dehydration or sepsis. (3) Deaths or serious injuries due to a medication error. (4) Elopements. (5) Transfers to a hospital as a result of injuries or accidents. (6) Complaints of patient abuse, whether or not confirmed by the facility. (7) Rape. (8) Surgery performed on the wrong patient or on the wrong body part. (9) Hemolytic transfusion reaction. (10) Infant abduction or infant discharged to the wrong family. (11) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence. (12) Notification of termination of any services vital to continued safe operation of the facility or the	H 0009	1. Reportable submitted and accepted for identified fall during complaint survey on 5/1/2025. 2. A 30 day look back audit was completed to ensure that no other falls experienced an injury of similar nature and went unreported. 3. NHA to educate DON/designee on events that require a report to be submitted. 4. DON/designee to audit falls and ensure reports are made for any falls with transfer and/or injury daily x 2 weeks, then 2x/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: **05/13/2025**

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

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

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H 0009	Continued from page 1 health and safety of its patients and personnel, including, but not limited to, the anticipated or actual termination of electric, gas, steam heat, water, sewer and local exchange of telephone service. (13) Unlicensed practice of a regulated profession. (14) Receipt of a strike notice. This REGULATION is not met as evidenced by:	H 0009		

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H 0009	Continued from page 2 Based on facility reports, and staff interview it was determined that the facility failed to notify the Department of Health of a reportable event. Findings include: During clinical record review on 5/1/25, at 9:37 a.m. Resident R1 had an unwitnessed fall on 4/19/25, that resulted in resident receiving a lumbar compression fracture (a type of spinal fracture where the vertebrae collapses). During clinical record review on 5/1/25, at 10:02 a.m. Resident R1 failed to have a diagnoses of lumbar compression fracture prior to fall on 4/19/25. During an interview on 5/1/25, at 2:00 p.m. Director of Nursing stated, "She didn't go out to the hospital, so I didn't report a new fracture." During an interview on 5/1/25, at 2:05 p.m. Nursing Home Administrator and Director of Nursing	H 0009		

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H 0009	Continued from page 3 confirmed that the facility failed to notify the Department of Health of a reportable event.	H 0009		

Certified End Page

SPRING HILL REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 192902

SURVEY EXIT DATE: 05/01/2025

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