STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395742	A. BLDG: 00 B. WING:	01/24/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SOUTHWESTERN NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **452302**	**500 NORTH LEWIS RUN ROAD PITTSBURGH, PA 15122**

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F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey and a Civil Rights Compliance survey, completed on January 24, 2025, it was determined that Southwestern Nursing an Rehabilitation 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 as they relate to the Health portion of the survey.	F 0000		
F 0578 SS=D		F 0578		

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 0578 SS=D	Continued from page 1 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	1. R41 has a completed advanced directive, R75 has a completed advanced directive, R77 has a completed advanced directive. 2. A full house audit has been completed to ensure current residents have a current advanced directive. 3. New admissions to the facility will have the opportunity to formulate an advanced directive. Advanced Directives will be placed as an order in the medical record. Advanced directives will be reviewed on a quarterly basis with the IDT team and the resident and/or family. 4. The Social Service Director or designee will review new admission medical charts for advanced directives weekly x4 to ensure current advanced directives are in place. The QAPI committee will determine the need for further audits.	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0578 SS=D	Continued from page 2 directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 0578		

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F 0578 SS=D	Continued from page 3 Based on review of the facility policy and clinical records and staff interviews, it was determined that the facility failed to provide the opportunity to formulate an advance directive (written instructions such as a living will or durable power of attorney for health care for when the individual is incapacitated) for three of the eight residents reviewed (Resident R41, R75, and R77). Findings Include: A review of the facility policy "Advanced Directives" last reviewed 11/5/24, indicated the facility will comply with the requirements related to maintaining written policies and procedures regarding advance directives, including provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and formulate an advance directive. A review of the medical record indicated Resident R41 was readmitted to the facility on 5/24/24, with	F 0578		

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F 0578 SS=D	Continued from page 4 diagnoses that included muscle weakness, high blood pressure, and heart failure (heart cannot pump or fill adequately). A review of the clinical record failed to reveal an advance directive or documentation that Resident R41 was given the opportunity to formulate an Advanced Directive. A review of the clinical record indicated Resident R75 was admitted to the facility on 10/5/24, with diagnoses that included dyspnea (difficult or labored breathing), muscle weakness, and epilepsy (nerve cells in the brain are disturbed, causing seizures). A review of the clinical record failed to reveal an advance directive or documentation that Resident R75 was given the opportunity to formulate an Advanced Directive. A review of the clinical record indicated Resident R77 was admitted to the facility on 11/6/24, with diagnoses that include high blood pressure,	F 0578		

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F 0578 SS=D	Continued from page 5 dysphagia (difficulty swallowing), muscle weakness, and liver transplant status. A review of the clinical record failed to reveal an advance directive or documentation that Resident R77 was given the opportunity to formulate an Advanced Directive. During an interview on 1/24/25, at 9:39 a.m. the Director of Nursing (DON) confirmed that the clinical record did not include documentation that Resident R41, R75, and R77 were not afforded the opportunity to formulate Advance Directives, it was confirmed again with the Admissions Director on 1/24/25 at 10:42 a.m.. 28 Pa. Code: 201.29(b)(d)(j) Resident rights.	F 0578		
F 0637 SS=D		F 0637		

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F 0637 SS=D	Continued from page 6 483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by:	F 0637	1. MDS cannot be corrected. 2. Audit of residents starting hospice in the past 14 days will be completed by the RNAC or designee to ensure a significant change MDS has been completed. 3. Education will be completed with RNAC by the Regional Nurse Consultant on when to schedule a comprehensive assessment after a Significant Change in status. 4. Audits will be completed by RNAC consultant or designee weekly for 4 weeks for all residents starting hospice care for scheduling and completion of a Significant Change MDS. The QAPI committee will determine the need for further audits.	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0637 SS=D	Continued from page 7 Based on clinical record review and staff interview, it was determined that the facility failed to complete a significant change Minimum Data Set (MDS-assessments completed indicating a change in condition of a resident requiring change in care) assessment for one of four residents reviewed (Residents R27). Findings include: Review of the Resident Assessment Instrument 3.0 User's Manual (reference used to complete an MDS) effective October 2024, indicated that the facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. Review of the clinical record indicated that Resident R27 was admitted to the facility on 12/24/21. Review of the MDS dated 11/14/24, included	F 0637		

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F 0637 SS=D	Continued from page 8 diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), Wernicke's encephalopathy (a neurological disorder caused by thiamine deficiency, and marked by mental confusion, abnormal eye movements, and unsteady gait) and schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior). Review of Section O: Special Treatments, Procedures, and Programs revealed at the time of the MDS, Resident R27 did not receive hospice services. Review of a physician order dated 11/27/24, indicated Resident R27 was admitted to hospice care (a special model of care for patients who are in the late phase of an incurable illness and wish to receive end-of-life care). Review of Resident R27's MDS assessments revealed a MDS significant change was not completed to include hospice services. During an interview on 1/22/25, at 2:01 p.m. the	F 0637		

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F 0637 SS=D	Continued from page 9 Director of Nursing confirmed that a Significant Change MDS assessment for Resident R27 was not completed. During an interview on 1/24/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed the facility failed to complete a Significant Change Minimum Data Set for one of four residents. 28 Pa. Code: 211.5(f) Clinical records.	F 0637		
F 0641 SS=E	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	1. MDS cannot be corrected. 2. and 3. Education will be completed with Social Services by the Regional Nurse Consultant on the accuracy of section B0700 and C0100 of the MDS. 4. Five random audits will be completed by RNAC or designee weekly for 4 weeks of residents MDS to ensure accuracy of sections B0700 and C0100. The QAPI committee will determine the need for further audits.	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/10/2025**

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F 0641 SS=E	Continued from page 10 Based on review of the Resident Assessment Instrument User's Manual and clinical records, and staff interview, it was determined that the facility failed to make certain that comprehensive Minimum Data Set (MDS - periodic assessment of care needs) assessments were accurate and fully completed for seven of eight residents without a BIMS assessment completed (Resident R7, R21, R22, R24, R38, R43, and R60). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing MDS Assessments dated October 2018, and updated October 2024, indicated that Section C: Cognitive Patterns, Question C0100 "Should Brief Interview for Mental Status Be Conducted?" (BIMS) should be coded as "0" if the resident is rarely/never understood, or it should be coded "1", and the BIMS assessment should be completed if the resident is at least sometimes understood. Section D: Mood, Question	F 0641		

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F 0641 SS=E	Continued from page 11 D0100 "Should Resident Mood Interview Be Conducted?" should be coded as "0" if the resident is rarely/never understood, and or it should be coded "1", and the assessment should be completed if the resident is at least sometimes understood. -Resident R7 had an MDS completed on 12/13/24. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R7 is "sometimes understood." Review of Section C: Cognitive Patterns, and Section D: Mood were indicated that Resident R7 is rarely understood, and the BIMS assessment and Resident Mood Interview were not completed. -Resident R21 had an MDS completed on 11/14/24. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R21 is "usually understood." Review of Section C: Cognitive Patterns, and Section D: Mood were indicated that Resident R21 is rarely understood, and the BIMS assessment and Resident Mood Interview were not completed.	F 0641		

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F 0641 SS=E	Continued from page 12 -Resident R22 had an MDS completed on 1/2/25. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R22 is "understood." Review of Section C: Cognitive Patterns, and Section D: Mood were indicated that Resident R22 is rarely understood, and the BIMS assessment and Resident Mood Interview were not completed. -Resident R24 had an MDS completed on 1/7/25. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R24 is "sometimes understood." Review of Section C: Cognitive Patterns, and Section D: Mood were indicated that Resident R24 is rarely understood, and the BIMS assessment and Resident Mood Interview were not completed. -Resident R38 had an MDS completed on 10/16/24. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R38 is "sometimes understood." Review of Section	F 0641		

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F 0641 SS=E	Continued from page 13 C: Cognitive Patterns, and Section D: Mood were indicated that Resident R38 is rarely understood, and the BIMS assessment and Resident Mood Interview were not completed. -Resident R43 had an MDS completed on 12/27/24. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R43 is "sometimes understood." Review of Section C: Cognitive Patterns, and Section D: Mood were indicated that Resident R43 is rarely understood, and the BIMS assessment and Resident Mood Interview were not completed. -Resident R60 had an MDS completed on 12/19/24. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R60 is "sometimes understood." Review of Section C: Cognitive Patterns, and Section D: Mood were indicated that Resident R60 is rarely understood, and the BIMS assessment and Resident Mood Interview were not completed.	F 0641		

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F 0641 SS=E	Continued from page 14 During an interview on 1/24/25, at 11:26 a.m. Registered Nurse Assessment Coordinator Employee E1 confirmed that the above MDS assessments were not accurate. During an interview on 1/24/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to make certain that comprehensive Minimum Data Set assessments were accurate for seven of eight residents. 28 Pa. Code: 211.5(f) Clinical records.	F 0641		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 15 483.25 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. Resident R27 is currently being fed by staff for all meals. Hospice and physician will be notified if R27 has a decrease in fluid intake, for new orders. 2. The last 14 days of all re-admissions and new admission discharge paperwork will be reviewed by the DON or designee to ensure instructions for fluid recommendations are followed. 3. Licensed staff will be in serviced on reviewing all re-admissions and new admission's discharge records to ensure fluid recommendations are reviewed and implemented. 4. The Director of Nursing or designee will review discharge paperwork for all re-admissions and new admissions to ensure fluid recommendations have been reviewed and implemented weekly x4 weeks. The QAPI committee will determine the need for further audits.	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/10/2025**

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 0684 SS=D	Continued from page 16 Based on review of facility policies and documents, clinical records, and staff interviews, it was determined that the facility failed to provide care and services after hospitalization for one of three residents (Resident R27). Review of the facility policy, "Resident Hydration and Prevention of Dehydration" dated 11/5/24, previously dated 11/30/23, indicated the facility will strive to provide adequate hydration and to prevent dehydration. Review of the clinical record indicated that Resident R27 was admitted to the facility on 12/24/21. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 11/14/24, included diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), Wernicke's encephalopathy (a neurological disorder caused by thiamine deficiency, and marked by mental confusion, abnormal eye movements, and unsteady	F 0684		

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F 0684 SS=D	Continued from page 17 gait) and schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior). Review of Resident R27's plan of care for "problem/potential problem with nutrition and/or hydration status" dated 2/1/22, with a revision on 9/23/24, failed to include interventions related to hydration status. Review of Resident R27's Kardex (document that outlines the patients' ADLs, continence levels, and behaviors, as well as physician, advanced directives, diet, and allergies) utilized by nurse aide staff, failed to include instructions on hydration status. Review of hospital discharge paperwork dated 6/13/24, indicated Resident R27 had been admitted for acute metabolic encephalopathy (alteration in consciousness caused by a chemical imbalance affecting the brain, often caused by infections or dehydration) and hypernatremia (high sodium levels in the blood, often caused by dehydration), and a	F 0684		

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F 0684 SS=D	Continued from page 18 urinary tract infection. The paperwork indicated that while in the hospital, Resident R27 was treated with intravenous fluids for dehydration with hypernatremia, and it was noted: "Hypernatremia, secondary to dehydration." "Overall, she is not eating and drinking adequately which is contributing to dehydration." "Upon discharge nursing will be asked to push oral fluids." "It is thought she is having poor intake of food, water." Review of Resident R27's progress notes after her hospitalization with treatment for dehydration failed to reveal any notes related to fluid status. Review of Resident R27's physician's orders after hospitalization with treatment for dehydration failed to reveal any orders related to monitoring fluid status. Review of Resident R27's plan of care failed to reveal any interventions after her hospitalization with	F 0684		

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F 0684 SS=D	Continued from page 19 treatment for dehydration related to monitoring fluid status. During an interview on 1/24/25, at approximately 1:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide care and services after hospitalization for one of three residents. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa.. Code: 211.10(c)(d) Resident rights. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.	F 0684		
F 0758 SS=D		F 0758		

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F 0758 SS=D	Continued from page 20 483.45(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 R23 has a correct diagnosis for Seroquel and the care plan has been updated and behavior monitoring is in place. 2. Current residents on antipsychotics will be reviewed to ensure the medications have the correct diagnosis, the care plan is updated, and behavior monitoring is in place. 3. The DON or designee will in service the licensed staff on correct diagnoses for antipsychotics, updating the care plans and implementing behavior charting. 4. The DON or designee will review new orders for antipsychotics medications during the clinical meeting to ensure antipsychotic medications have the correct diagnosis, the careplan is updated and behavior monitoring is in place weekly x4 weeks. The QAPI committee will determine the need for further audits.	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0758 SS=D	Continued from page 21 §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		

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F 0758 SS=D	Continued from page 22 Based on a review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that each resident's drug regimen was free from unnecessary drugs used without adequate indications for use for one of five residents. (Resident R23). Findings include: Review of the facility policy, "Medication Use: Psychotropic" dated 11/5/24, indicated; "Residents will not receive medications that are not clinically indicated to treat a specific condition." Review of Resident R23's admission record indicated she was initially admitted to the facility on 7/27/15, and readmitted on 5/27/16. Review of Resident R23's Minimum Data Set (MDS- periodic assessment of care needs) assessment dated 11/4/24, included diagnoses of multiple sclerosis (a disease that affects central nervous system), dementia (a group of symptoms	F 0758		

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F 0758 SS=D	Continued from page 23 that affects memory, thinking and interferes with daily life) without behaviors, and anxiety. Review of Section N: Medications revealed Resident R23 received antipsychotic medications in the seven days prior to the assessment. Review of a physician order dated 1/16/25, indicated Resident R23 received Seroquel (an anti-psychotic medication) 25 mg twice per day for anxiety. Review of Resident R23's care plan for the use of psychotropic behaviors initiated 8/13/24, indicated Resident R23 received psychotropic medication related to dementia. Review of Resident R23's progress notes from 7/1/24, through 1/24/25, failed to include documentation of unwanted behaviors. Review of behavior monitoring documentation for November 2024, December 2024, and January 2025 (through 1/24/25), failed to reveal any	F 0758		

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F 0758 SS=D	Continued from page 24 documented behaviors. During an interview 1/24/25, at approximately 1:00 p.m. Nursing Home Administrator and the Director of Nursing confirmed the facility failed to make certain that each resident's drug regimen was free from unnecessary drugs used without adequate indications for use for one of five residents. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.2(a)(c) Physician services. 28 Pa. Code: 211.9(a)(1)(d)(k) Pharmacy services. 28 Pa. Code: 211.12(c)(d)(5) Nursing services.	F 0758		
F 0812 SS=F		F 0812		

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F 0812 SS=F	Continued from page 25 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1. No residents were affected. 2. The dish machine is working properly and running at proper temperatures. Fan blades and the cover on the ceiling of the freezer have been cleaned. 3. Kitchen employees were in serviced by the District Manager regarding proper use of strips for measuring the sanitation level in dishwasher. The kitchen employees have been in serviced by the District Manager on the cleaning schedule of the fan blades and the cover on the ceiling of the freezer. 4. The Administrator/kitchen manager or designee will conduct inspections of the dish machine temps and sanitation, fan blades and the cover on the ceiling in the freezer to ensure they are in good working order and clean weekly x 4 weeks. The QAPI committee will determine the need for further audits.	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0812 SS=F	Continued from page 26 Based on observations and staff interviews it was determined that the facility failed to verify the dish washing temperature and staff education on the use of chemical sanitation to prevent the potential for cross contamination and failed to store food products in a manner to prevent foodborne illness in the main kitchen. Findings include: During an observation on 1/21/25 beginning at approximately 10:15 a. m., of the Main Kitchen the following concerns were identified: The dish machine was identified as high temperature, however, according to Dietary Aide(DA) Employee E3 who was assisting in running the dish machine with DA Employee E4 stated that the dish machine elements were not working and the machine was currently functioning as a low temp with chemicals used for sanitation. During an interview on 1/21/25, at 10:20 a.m.,	F 0812		

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F 0812 SS=F	Continued from page 27 Dietary Aides were asked to run a strip through the machine to show the level of sanitation. Neither employee stated that they were not trained how to run the strips and had not done so prior to using the machine. During an interview on 1/21/25, at 10:45 a.m., District Manager Dietary Employee E5 stated that the dish machine had not been functioning since 1/20/25 evening and that EcoLab (dishmachine vendor) staff had set the machine up for chemical use. The District Manager Employee E5 confirmed that staff had not been trained to perform test strip chemical testing. During an interview on 1/21/25, at 11:00 a.m., the Nursing Home Administrator confirmed that the staff were not trained how to perform necessary tasks to prevent the potential for cross contamination while using the dish machine. During an observation on 1/21/25 at 10:55 a. m., of the refrigerator leading to he deep freezer identified	F 0812		

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F 0812 SS=F	Continued from page 28 a gray fuzzy substance on the fan blades and cover and on the ceiling with food stored underneath which had the potential for food borne illness. During an interview on 1/21/25, at 11:00 a.m., the District Manager confirmed that the substance in the fans and ceiling had the potential for contamination of food which could cause potential for food borne illness. Pa Code: 211.6(c)(d)(f) Dietary services.	F 0812		
F 0848 SS=C		F 0848		

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F 0848 SS=C	Continued from page 29 483.70(m), 483.70(m)(2)(iii)(iv)(6) Binding Arbitration Agreements §483.70(m) Binding Arbitration Agreements. If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(2) The facility must ensure that: (iii) The agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and (iv) The agreement provides for the selection of a venue that is convenient to both parties. §483.70(n)((6) When the facility and a resident resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years after the resolution of that dispute on and be available for inspection upon request by CMS or its designee. This REQUIREMENT is not met as evidenced by:	F 0848	1. No residents were affected. 2. and 3. The facility will remove the Indemnification clause from all current admission agreements. Current residents or responsible parties will be sent the updated admissions agreement. 4. New admission files will be audited by the Administrator or designee for compliance with the new admissions agreement weekly for 4 weeks. The QAPI committee will determine the need for future audits.	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0848 SS=C	Continued from page 30 Based on review of the facility's admission and financial agreement and staff interviews, it was determined that the facility failed to ensure a neutral and fair arbitration process by ensuring both the resident or his or her representative, and the facility agree on the selection of a neutral arbitrator. Findings include: Review of facility's Admission Agreement packet, which contained the document "Admission and Financial Agreement" indicated that the "Indemnification" statement in the agreement indicated that the facility will not be indemnified or held harmless from injury to or death of any person or other resident, or for any damage to or loss of the property of any person or resident, caused by the acts or omissions of Resident to the fullest extent of the law. The facility's admission and financial agreement failed to identify the indemnification statement as an arbitration agreement and provide for the selection	F 0848		

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SOUTHWESTERN NURSING AND REHABILITATION CENTER	**500 NORTH LEWIS RUN ROAD PITTSBURGH, PA 15122**
STATE LICENSE NUMBER: **452302**	

(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 0848 SS=C	Continued from page 31 of a neutral arbitrator agreed upon by both parties as one is designated in the facility arbitration agreement, in accordance with §483.70(n)(2)(iii). Regulatory guidance defined a neutral Arbitrator as an impartial, or unbiased third-party decision maker, contracted with, and agreed to by both parties to resolve their dispute. To ensure a neutral arbitrator is selected, the facility should avoid even the appearance of bias, partiality, or a conflict of interest, and should promptly disclose to the resident or his or her representative the extent of any relationship which exists with an arbitrator or arbitration services company, including how often the facility has contracted with the arbitrator or arbitration service, and when the arbitrator or arbitration service has ruled for or against the facility. During an interview on 1/22/25, at 3:20 p.m. the Nursing Home Administrator confirmed the language of the admission/ financial agreement may appear to not identify the indemnification statement as arbitration and does not to afford a neutral and	F 0848		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395742	A. BLDG: __00_____ B. WING: _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0848 SS=C	Continued from page 32 fair arbitration process by ensuring both the resident or his or her representative, and the facility agree on the selection of a neutral arbitrator. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a)(j) Resident rights.	F 0848		
F 0941 SS=B		F 0941		

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 0941 SS=B	Continued from page 33 483.95(a) Communication Training §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. This REQUIREMENT is not met as evidenced by:	F 0941	1. The facility will ensure employees receive communication training on a yearly basis. 2. A full house employee file audit will be conducted to identify the training needs of each employee to ensure ongoing yearly training. 3. The Human Resources Director of designee will ensure that each employee of the facility receives communication training on a yearly basis by reviewing their training courses prior to their performance appraisal due date. If the training has been inadvertently missed, the employee will be trained on the missed course prior to the performance appraisal being completed. 4. The Administrator or designee will review 5 employee files due for performance review each month to ensure yearly training is completed weekly x4 weeks. The QAPI committee will determine the need for further audits.	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0941 SS=B	Continued from page 34 Based on review of facility personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on effective communication for eight of nine staff members (Employee E6, E7, E8, E9, E10, E11, E13, and E14). Findings include: Review of facility provided documents and training records revealed the following staff members did not have documented training on effective communication. Nurse Aide (NA) Employee E6 had a hire date of 9/16/21, failed to have effective communication in-service education between 9/16/23, and 9/16/24/24. NA Employee E7 had a hire date of 10/4/12, failed to have effective communication in-service education between 10/4/23, and 10/4/24.	F 0941		

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F 0941 SS=B	Continued from page 35 NA Employee E8 had a hire date of 10/14/13, failed to have effective communication in-service education between 10/14/23, and 10/14/24/24. NA Employee E9 had a hire date of 8/15/22, failed to have effective communication in-service education between 8/15/24, and 8/15/24. Central Supply Employee E10 had a hire date of 11/3/21, failed to have effective communication in-service education between 11/3/23, and 11/3/24. Activities Assistant Employee E11 had a hire date of 1/12/22, failed to have effective communication in-service education between 1/12/24, and 1/12/25. Registered Nurse Employee E13 had a hire date of 10/6/22, failed to have effective communication in-service education between 10/6/23, and 10/6/24. Licensed Practical Nurse Employee E14 had a hire date of 9/6/22, failed to have effective communication in-service education between	F 0941		

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F 0941 SS=B	Continued from page 36 9/6/23, and 9/6/24. During an interview on 1/24/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on effective communication for eight of nine staff members. 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 0941		
F 0942 SS=B		F 0942		

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 0942 SS=B	Continued from page 37 483.95(b) Resident Rights Training §483.95(b) Resident's rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively. This REQUIREMENT is not met as evidenced by:	F 0942	1. The facility will ensure employees receive resident rights on a yearly basis. 2. A full house employee file audit will be conducted to identify the training needs of each employee to ensure ongoing yearly training. 3. The Human Resources Director of designee will ensure that each employee of the facility receives resident rights training on a yearly basis by reviewing their training courses prior to their performance appraisal due date. If the training has been inadvertently missed, the employee will be trained on the missed course prior to the performance appraisal being completed. 4. The Administrator or designee will review 5 employee files due for performance review each month to ensure yearly training is completed weekly x4 weeks. The QAPI committee will determine the need for further audits.	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0942 SS=B	Continued from page 38 Based on review of facility personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on resident rights for eight of nine staff members (Employee E6, E7, E8, E9, E10, E11, E12, and E14). Findings include: Review of facility provided documents and training records revealed the following staff members did not have documented training on resident rights. Nurse Aide (NA) Employee E6 had a hire date of 9/16/21, failed to have resident rights in-service education between 9/16/23, and 9/16/24/24. NA Employee E7 had a hire date of 10/4/12, failed to have resident rights in-service education between 10/4/23, and 10/4/24. NA Employee E8 had a hire date of 10/14/13, failed to have resident rights in-service education	F 0942		

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F 0942 SS=B	Continued from page 39 between 10/14/23, and 10/14/24/24. NA Employee E9 had a hire date of 8/15/22, failed to have resident rights in-service education between 8/15/24, and 8/15/24. Central Supply Employee E10 had a hire date of 11/3/21, failed to have resident rights in-service education between 11/3/23, and 11/3/24. Activities Assistant Employee E11 had a hire date of 1/12/22, failed to have resident rights in-service education between 1/12/24, and 1/12/25. Maintenance Employee E12 had a hire date of 12/1/xx, failed to have resident rights in-service education between 12/1/23, and 12/1/24. Licensed Practical Nurse Employee E14 had a hire date of 9/6/22, failed to have resident rights in-service education between 9/6/23, and 9/6/24. During an interview on 1/24/25, at approximately	F 0942		

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F 0942 SS=B	Continued from page 40 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on resident rights for eight of nine staff members. 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 0942		
F 0943 SS=E		F 0943		

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F 0943 SS=E	Continued from page 41 483.95(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. The facility will ensure employees receive abuse, neglect and exploitation training on a yearly basis. 2. A full house employee file audit will be conducted to identify the training needs of each employee to ensure ongoing yearly training. 3. The Human Resources Director of designee will ensure that each employee of the facility receives abuse, neglect and exploitation training on a yearly basis by reviewing their training courses prior to their performance appraisal due date. If the training has been inadvertently missed, the employee will be trained on the missed course prior to the performance appraisal being completed. 4. The Administrator or designee will review 5 employee files due for performance review each month to ensure yearly training is completed weekly x4 weeks. The QAPI committee will determine the need for further audits.	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0943 SS=E	Continued from page 42 Based on review of facility personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on abuse and neglect prevention for three of nine staff members (Employee E9, E13, and E14). Findings include: Review of facility provided documents and training records revealed the following staff members did not have documented training on abuse and neglect prevention. Nurse Aide (NA) Employee E9 had a hire date of 8/15/22, failed to have abuse and neglect prevention in-service education between 8/15/24, and 8/15/24. Registered Nurse Employee E13 had a hire date of 10/6/22, failed to have abuse and neglect prevention in-service education between 10/6/23, and 10/6/24. Licensed Practical Nurse Employee E14 had a hire date of 9/6/22, failed to have abuse and neglect	F 0943		

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F 0943 SS=E	Continued from page 43 prevention in-service education between 9/6/23, and 9/6/24. During an interview on 1/24/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on abuse and neglect prevention for three of nine staff members. 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		
F 0944 SS=B		F 0944		

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F 0944 SS=B	Continued from page 44 483.95(d) QAPI Training §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by:	F 0944	1. The facility will ensure employees receive QAPI training on a yearly basis. 2. A full house employee file audit will be conducted to identify the training needs of each employee to ensure ongoing yearly training. 3. The Human Resources Director of designee will ensure that each employee of the facility receives QAPI training on a yearly basis by reviewing their training courses prior to their performance appraisal due date. If the training has been inadvertently missed, the employee will be trained on the missed course prior to the performance appraisal being completed. 4. The Administrator or designee will review 5 employee files due for performance review each month to ensure yearly training is completed weekly x4 weeks. The QAPI committee will determine the need for further audits.	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0944 SS=B	Continued from page 45 Based on review of facility personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on Quality Assurance and Performance Improvement (QAPI) for eight of nine staff members (Employee E6, E7, E8, E9, E10, E11, E13, and E14). Findings include: Review of facility provided documents and training records revealed the following staff members did not have documented training on QAPI. Nurse Aide (NA) Employee E6 had a hire date of 9/16/21, failed to have QAPI in-service education between 9/16/23, and 9/16/24/24. NA Employee E7 had a hire date of 10/4/12, failed to have QAPI in-service education between 10/4/23, and 10/4/24. NA Employee E8 had a hire date of 10/14/13,	F 0944		

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F 0944 SS=B	Continued from page 46 failed to have QAPI in-service education between 10/14/23, and 10/14/24/24. NA Employee E9 had a hire date of 8/15/22, failed to have QAPI in-service education between 8/15/24, and 8/15/24. Central Supply Employee E10 had a hire date of 11/3/21, failed to have QAPI in-service education between 11/3/23, and 11/3/24. Activities Assistant Employee E11 had a hire date of 1/12/22, failed to have QAPI in-service education between 1/12/24, and 1/12/25. Registered Nurse Employee E13 had a hire date of 10/6/22, failed to have QAPI in-service education between 10/6/23, and 10/6/24. Licensed Practical Nurse Employee E14 had a hire date of 9/6/22, failed to have QAPI in-service education between 9/6/23, and 9/6/24.	F 0944		

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F 0944 SS=B	Continued from page 47 During an interview on 1/24/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on QAPI for eight of nine staff members. 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 0944		
F 0945 SS=D		F 0945		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395742	A. BLDG: 00 B. WING:	01/24/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SOUTHWESTERN NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **452302**	**500 NORTH LEWIS RUN ROAD PITTSBURGH, PA 15122**

(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 0945 SS=D	Continued from page 48 483.95(e) Infection Control Training §483.95(e) Infection control. A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at §483.80(a)(2). This REQUIREMENT is not met as evidenced by:	F 0945	1. The facility will ensure employees receive infection control training on a yearly basis. 2. A full house employee file audit will be conducted to identify the training needs of each employee to ensure ongoing yearly training. 3. The Human Resources Director of designee will ensure that each employee of the facility receives infection control training on a yearly basis by reviewing their training courses prior to their performance appraisal due date. If the training has been inadvertently missed, the employee will be trained on the missed course prior to the performance appraisal being completed. 4. The Administrator or designee will review 5 employee files due for performance review each month to ensure yearly training is completed weekly x4 weeks. The QAPI committee will determine the need for further audits.	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/07/2025**

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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STATE LICENSE NUMBER: **452302**	

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F 0945 SS=D	Continued from page 49 Based on review of facility personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on infection control for one of nine staff members (Employee E13). Findings include: Review of facility provided documents and training records revealed the following staff members did not have documented training on infection control. Registered Nurse Employee E13 had a hire date of 10/6/22, failed to have infection control in-service education between 10/6/23, and 10/6/24. During an interview on 1/24/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on infection control for eight of nine staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee.	F 0945		

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 0945 SS=D	Continued from page 50 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.	F 0945		
F 0946 SS=C		F 0946		

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 0946 SS=C	Continued from page 51 483.95(f)(1)(2) Compliance and Ethics Training §483.95(f) Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at §483.85- §483.95(f)(1) An effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program. §483.95(f)(2) Annual training if the operating organization operates five or more facilities. This REQUIREMENT is not met as evidenced by:	F 0946	1. The facility will ensure employees receive Compliance and Ethics training on a yearly basis. 2. A full house employee file audit will be conducted to identify the training needs of each employee to ensure ongoing yearly training. 3. The Human Resources Director of designee will ensure that each employee of the facility receives Compliance and Ethics training on a yearly basis by reviewing their training courses prior to their performance appraisal due date. If the training has been inadvertently missed, the employee will be trained on the missed course prior to the performance appraisal being completed. 4. The Administrator or designee will review 5 employee files due for performance review each month to ensure yearly training is completed weekly x4 weeks. The QAPI committee will determine the need for further audits.	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0946 SS=C	Continued from page 52 Based on review of facility personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on compliance and ethics for nine of nine staff members (Employee E6, E7, E8, E9, E10, E11, E12, E13, and E14). Findings include: Review of facility provided documents and training records revealed the following staff members did not have documented training on compliance and ethics. Nurse Aide (NA) Employee E6 had a hire date of 9/16/21, failed to have compliance and ethics in-service education between 9/16/23, and 9/16/24/24. NA Employee E7 had a hire date of 10/4/12, failed to have compliance and ethics in-service education between 10/4/23, and 10/4/24. NA Employee E8 had a hire date of 10/14/13,	F 0946		

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 0946 SS=C	Continued from page 53 failed to have compliance and ethics in-service education between 10/14/23, and 10/14/24/24. NA Employee E9 had a hire date of 8/15/22, failed to have compliance and ethics in-service education between 8/15/24, and 8/15/24. Central Supply Employee E10 had a hire date of 11/3/21, failed to have compliance and ethics in-service education between 11/3/23, and 11/3/24. Activities Assistant Employee E11 had a hire date of 1/12/22, failed to have compliance and ethics in-service education between 1/12/24, and 1/12/25. Maintenance Employee E12 had a hire date of 12/1/xx, failed to have compliance and ethics in-service education between 12/1/23, and 12/1/24. Registered Nurse Employee E13 had a hire date of 10/6/22, failed to have compliance and ethics in-service education between 10/6/23, and 10/6/24.	F 0946		

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 0946 SS=C	Continued from page 54 Licensed Practical Nurse Employee E14 had a hire date of 9/6/22, failed to have compliance and ethics in-service education between 9/6/23, and 9/6/24. During an interview on 1/24/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on compliance and ethics for eight of nine staff members. 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 0946		
F 0947 SS=F		F 0947		

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 0947 SS=F	Continued from page 55 483.95(g)(1)-(4) Required In-Service Training for Nurse Aides §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:	F 0947	1. The facility will ensure certified nursing assistants receive 12 hours of in-service training on a yearly basis. 2. A full house employee file audit will be conducted to identify the training needs of each nursing assistant to ensure ongoing yearly training. 3. The Human Resources Director of designee will ensure that each nursing assistant of the facility receives 12 hours of inservice training on a yearly basis by reviewing their training courses prior to their performance appraisal due date. If the training has been inadvertently missed, the employee will be trained on the missed course prior to the performance appraisal being completed. 4. The Administrator or designee will review 5 employee files due for performance review each month to ensure yearly training is completed weekly x4 weeks. The QAPI committee will determine the need for further audits.	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0947 SS=F	Continued from page 56 Based on review of staff education records and interviews, it was determined that the facility failed to conduct at least 12 hours of in-service education, within 12 months of their hire date anniversary, for nurse aides as required for four of four nurse aides (Employees E6, E7, E8, and E9). Finding include: Review of education records for Employees E6, E7, E8, and E9 revealed the following: Nurse Aide (NA) Employee E6 had a hire date of 9/16/21, with approximately 10.25 hours of in-service education between 9/16/23, and 9/16/24. NA Employee E7 had a hire date of 10/4/12, with approximately 9.75 hours of in-service education between 10/4/23, and 10/4/24. NA Employee E8 had a hire date of 10/14/13, with approximately 10.00 hours of in-service education between 10/14/23, and 10/14/24.	F 0947		

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F 0947 SS=F	Continued from page 57 NA Employee E9 had a hire date of 8/15/22, with approximately 6.75 hours of in-service education between 8/15/23, and 8/15/24. During an interview on 1/24/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide the required 12 hours annual in-service education within 12 months of their hire date anniversary for four of four nurse aides. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(c) Staff development.	F 0947		
F 0949 SS=C		F 0949		

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F 0949 SS=C	Continued from page 58 483.95(i) Behavioral Health Training §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.71. This REQUIREMENT is not met as evidenced by:	F 0949	1. The facility will ensure employees receive behavioral health training on a yearly basis. 2. A full house employee file audit will be conducted to identify the training needs of each employee to ensure ongoing yearly training. 3. The Human Resources Director of designee will ensure that each employee of the facility receives behavioral health training on a yearly basis by reviewing their training courses prior to their performance appraisal due date. If the training has been inadvertently missed, the employee will be trained on the missed course prior to the performance appraisal being completed. 4. The Administrator or designee will review 5 employee files due for performance review each month to ensure yearly training is completed weekly x4 weeks. The QAPI committee will determine the need for further audits.	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0949 SS=C	Continued from page 59 Based on review of facility personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on behavioral health for eight of nine staff members (Employee E6, E7, E8, E9, E10, E11, E13, and E14). Findings include: Review of facility provided documents and training records revealed the following staff members did not have documented training on behavioral health. Nurse Aide (NA) Employee E6 had a hire date of 9/16/21, failed to have behavioral health in-service education between 9/16/23, and 9/16/24/24. NA Employee E7 had a hire date of 10/4/12, failed to have behavioral health in-service education between 10/4/23, and 10/4/24. NA Employee E8 had a hire date of 10/14/13, failed to have behavioral health in-service education	F 0949		

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F 0949 SS=C	Continued from page 60 between 10/14/23, and 10/14/24/24. NA Employee E9 had a hire date of 8/15/22, failed to have behavioral health in-service education between 8/15/24, and 8/15/24. Central Supply Employee E10 had a hire date of 11/3/21, failed to have behavioral health in-service education between 11/3/23, and 11/3/24. Activities Assistant Employee E11 had a hire date of 1/12/22, failed to have behavioral health in-service education between 1/12/24, and 1/12/25. Registered Nurse Employee E13 had a hire date of 10/6/22, failed to have behavioral health in-service education between 10/6/23, and 10/6/24. Licensed Practical Nurse Employee E14 had a hire date of 9/6/22, failed to have behavioral health in-service education between 9/6/23, and 9/6/24. During an interview on 1/24/25, at approximately	F 0949		

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F 0949 SS=C	Continued from page 61 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on behavioral health for eight of nine staff members. 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 0949		

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P 1570	Staff development. (3) Emergency preparedness in accordance with 42 CFR 483.73(d) (relating to emergency preparedness). This REGULATION is not met as evidenced by:	P 1570	1. The facility will ensure employees receive Emergency Preparedness on a yearly basis. 2. A full house employee file audit will be conducted to identify the training needs of each employee to ensure ongoing yearly training. 3. The Maintenance Manager and Human Resources Director or designee will ensure that each employee of the facility receives Emergency Preparedness training on a yearly basis by reviewing their training courses prior to their performance appraisal due date. If the training has been inadvertently missed, the employee will be trained on the missed course prior to the performance appraisal being completed. 4. The Administrator or designee will review 5 employee files due for performance review each month to ensure yearly training is completed weekly x4 weeks. The QAPI committee will determine the need for further audits.	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/07/2025**

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

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P 1570	Continued from page 1 Based on a review of employee education records and staff interviews, it was determined that the facility failed to ensure that employees completed the required annual emergency preparedness education for four of four employees reviewed (Nurse Aide Employees E6, E7, E8, and E9). Findings include: Review of facility provided documents revealed the following staff members did not have documented training on emergency preparedness. Nurse Aide (NA) Employee E6 had a hire date of 9/16/21, failed to have emergency preparedness in-service education between 9/16/23, and 9/16/24/24. NA Employee E7 had a hire date of 10/4/12, failed to have emergency preparedness in-service education between 10/4/23, and 10/4/24. NA Employee E8 had a hire date of 10/14/13,	P 1570		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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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
P 1570	Continued from page 2 failed to have emergency preparedness in-service education between 10/14/23, and 10/14/24/24. NA Employee E9 had a hire date of 8/15/22, failed to have emergency preparedness in-service education between 8/15/24, and 8/15/24. During an interview on 1/24/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure that employees completed the required annual emergency preparedness education for four of four employees reviewed.	P 1570		
P 5520		P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395742	A. BLDG: 00 B. WING:	01/24/2025

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P 5520	Continued from page 3 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	1. The facility is unable to retroactively correct the staffing ratio for days: 12/22/24, 12/24/24, 12/28/24, 1/10/25, 1/11/25, 1/12/25, 1/13/25, 1/14/25, 1/15/25,n1/16/25, 1/19/25, 1/29/25, and 1/21/25. 2. The facility will schedule CNA's to state ratio. Call outs will be monitored by NHA/DON and/or designee. Facility staff as well as staffing agencies will be utilized to facilitate replacement/procurement of staff. 3. NHA or designee will educate the scheduling coordinator on the requirements of CAN raios of 1 to for day shifts, 1 to for afternoon shifts and 1 to for midnight shifts. The staffing ratio will be monitored weekly x4 weeks. 4. NHA or designee will randomly audit the staffing ratio weekly x4 weeks. Findings will be summarized and brought to the quality assurance and performance improvement committee and reviewed for any further monitoring or changes needed.	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/07/2025**

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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P 5520	Continued from page 4 Based on review of nursing schedules, nursing staffing documents and staff interview, it was determined that the facility failed to provide the State required minimum of one Nurse Aide (NA) per 10 residents on the daylight shift for nine out of 21 days (12/22/24, 12/24/24, 12/28/24, 1/14/25, 1/15/25, 1/16/25, 1/19/25, 1/20/25 and 1/21/25), and failed to provide the State required minimum of one NA per 11 residents on four out of 21 evening shifts (12/22/24, 1/13/25, 1/14/25 and 1/15/25), and failed to provide the State required minimum of one NA per 15 residents on seven of 21 midnight shifts (12/22/24, 1/10/25, 1/11/25, 1/12/25, 1/13/25, 1/15/25, and 1/21/25). Findings include: Review of the facility's 3-week nurse staffing schedules (12/22/24- 1/22/25) did not include the State required minimum of Nurse Aides (NA) on: -Daylight shift: 12/22/24. needed 7.80, and only had 7.48. Census	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395742	A. BLDG: __00_____ B. WING: _____	01/24/2025

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P 5520	Continued from page 5 was 78. 12/24/24, needed 7.90, and only had 6.25. Census was 79. 12/28/24, needed 7.90, and only had 6.53. Census was 79. 1/14/25, needed 7.80, and only had 7.43. Census was 78. 1/15/25, needed 7.70, and only had 7.47. Census was 77. 1/16/25, needed 7.70, and only had 7.60. Census was 77. 1/19/25, needed 8.0, and only had 7.38. Census was 80. 1/20/25, needed 8.0, and only had 6.14. Census was 80. 1/21/25, needed 8.10, and only had 7.46. Census was 81. -Evening shifts: 12/22/24, needed 7.09, and only had 7.07. Census was 78. 1/13/25, needed 7.55, and only had 7.26. Census was 83.	P 5520		

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P 5520	Continued from page 6 1/14/25, needed 7.09, and only had 6.92. Census was 78. 1/15/25, needed 7.0, and only had 6.58. Census was 77. -Midnight shifts: 12/22/24, needed 5.20, and only had 4.25. Census was 78. 1/10/25, needed 5.60, and only had 5.36. Census was 84. 1/11/25, needed 5.60, and only had 5.36. Census was 84. 1/12/25, needed 5.60, and only had 4.98. Census was 84. 1/13/25, needed 5.53, and only had 5.30. Census was 83. 1/15/25, needed 5.13 and only had 4.21. Census was 77. 1/21/25, needed 5.40 and only had 5.33. Census was 81. During an interview on 1/23/25 at 10:36 a.m. the Nursing Home Administrator confirmed that the	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 7 facility failed to provide the State required minimum of one Nurse Aide (NA) per 10 residents on the daylight shift for nine out of 21 days (12/22/24, 12/24/24, 12/28/24, 1/14/25, 1/15/25, 1/16/25, 1/19/25, 1/20/25 and 1/21/25), and failed to provide the State required minimum of one NA per 11 residents on four out of 21 evening shifts (12/22/24, 1/13/25, 1/14/25 and 1/15/25), and failed to provide the State required minimum of one NA per 15 residents on seven of 21 midnight shifts (12/22/24, 1/10/25, 1/11/25, 1/12/25, 1/13/25, 1/15/25, and 1/21/25).	P 5520		
P 5530		P 5530		

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 5530	Continued from page 8 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. The facility is unable to retroactively correct the staffing ratio for days: 1/10/25, 1/13/25, 1/19/25, and 1/21/25. 2. The facility will schedule LPNs to state ratio of 1 to 25 for day shifts, and 1 to 40 for midnight shifts. Call outs will be monitored by NHA/DON and/or designee. Facility staff as well as staffing agencies will be utilized to facilitate replacement/procurement of staff. 3. NHA or designee will educate the scheduling coordinator on the requirements of LPN ratios of 1 to 25 for day shifts, and 1 to 40 for midnight shifts. The staffing ratio will be monitored weekly x4 weeks. 4. Findings will be summarized and brought to the quality assurance and performance improvement committee and reviewed for any further monitoring or changes needed.	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/07/2025**

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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P 5530	Continued from page 9 Based on review of nursing time schedules and staff interview it was determined that the facility failed to provide a minimum of one licensed practical nurse (LPN) per 25 residents on one of 21 day shift (1/19/25) and for three of 21 days on the night shift (1/10/25, 1/13/25 and 1/21/25). Findings include: Review of facility census data, nursing time schedules from 12/22/24 through 1/22/25, revealed the following LPN staffing shortage: Day shift: 1/19/25 census 80 23.98 actual hours 25.60 hours required. Night shift: 1/10/25 census 84 16.60 actual hours 16.80 hours required. 1/13/25 census 83 16.00 actual hours 16.60 hours required.	P 5530		

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 5530	Continued from page 10 1/21/25 census 81 16.00 actual hours 16.20 hours required. During an interview on 1/22/25, at 10:36 a.m. the Nursing Home Administrator confirmed the facility failed to provide the minimum of LPN's on the above days as required.	P 5530		

Certified End Page

SOUTHWESTERN NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 452302

SURVEY EXIT DATE: 01/24/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

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

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY