STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395028	A. Building B. Wing	07/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Squirrel Hill Wellness and Rehabilitation Center	2025 Wightman Street Pittsburgh, PA 15217

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26071 Based on review of facility policies, clinical records, incident reports, employee statements and staff interview, it was determined that the facility failed to ensure that a resident was free from neglect by not providing the necessary services, which resulted in actual physical harm (right femur fracture) for one of 10 residents reviewed (Resident R1). Findings include: A review of the facility policy Abuse and Neglect Prevention dated 5/26/21, indicated the facility will prohibit abuse, neglect, involuntary seclusion, and misappropriation of property for all residents through the implementation of screening, training, prevention, identification, investigation, protection, and reporting. A review of the facility policy Hoyer Lift-Proper Use dated 5/26/21, indicated residents who are unable to transfer themselves independently or with minimum assistance shall be transferred safely with the Hoyer lift (a mechanical lift used to transfer residents) and two nursing staff are needed to transfer a resident using a Hoyer lift. A review of the clinical record indicated Resident R1 was readmitted to the facility on [DATE], with diagnoses that included heart failure, schizophrenia (a mental disorder that causes hallucinations and delusions), history of a right hip fracture, and osteoporosis (a weakening of the bones). A review of Resident R1's quarterly MDS assessment (MDS-Minimum Data Set Assessment: periodic assessment of resident care needs) dated 5/24/21, indicated that the diagnoses remained current. A review of Resident R1's care plan dated 5/26/21, indicated that Resident R1 was at risk of falls due to weakness and deconditioning, and impaired safety awareness. Facility staff would provide Resident R1 with appropriate assistive devices for safe transfers. The care plan stated that the resident required a mechanical lift with assist of two for transfers. A review of Resident R1's current ADL sheet (Activities of Daily living sheet: document that provides resident level of assistance for nursing staff) undated, indicated that the resident was a transfer assist of two staff with a mechanical lift. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of Resident R1's physician order dated 2/18/21, indicated that Resident R1 was to be transferred with a Hoyer lift (mechanical lift). A review of incident report dated 7/4/21, indicated at 10:38 a.m. Resident R1 complained of right lower extremity pain after transfer from the bed to the wheelchair. The physician was notified and examined the resident and ordered x-rays to rule out a fracture. A review of NA Employee E1 Witness Statement dated 7/7/21, indicated that the nurse aide pivoted (stand and turned) Resident R1 from bed to chair with NA Employee E2 without using a mechanical lift. A review of NA Employee E2 Witness Statement dated 7/7/21, indicated the nurse aide did not use a lift and had a hard time getting Resident R1 into the chair and when Resident R1 was in the chair she complained that her leg was broken. A review of an Orthopedic Consult dated 7/6/21, indicated a closed fracture of the distal end of the right femur. A review of NA Employee E1's employee transcript dated 5/18/21, indicated she had received education on proper body mechanics, and she was educated on abuse. A review of NA Employee E2's employee transcript dated 6/29/21, indicated she received education on proper body mechanics, and she was educated on abuse. During an interview on 7/16/21, at 11:00 a.m. the NHA confirmed the facility's investigation of the incident found that it involved a substantiated neglect of service against NA Employee E1 and E2, as they did not use a mechanical lift as ordered to transfer Resident R1. During an interview on 7/16/21, at 10:30 a.m. NA Employee E1 stated she transferred Resident R1 without a mechanical lift because someone on the floor told her it was ok. She stated she rarely worked with Resident R1. She stated she should have checked the transfer status for Resident R1 instead of listening to someone on the floor. During an interview on 7/16/21, at 11:05 a.m. NA Employee E2 stated that Resident R1 kept saying she was a transfer with a mechanical lift, and she could not stand, but NA Employee E1 said they could transfer with a 2 person assist. During an interview on 7/16/21, at 10:20 a.m. Medical Director Employee E3 confirmed Resident R1 could not stand or walk prior to the incident, thus was ordered a mechanical lift for all transfers. During an interview on 7/16/21, at 2:30 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure that Resident R1 was free from neglect by not providing the necessary services, which resulted in Resident R1 suffering physical harm from a fractured right femur. 28 Pa Code 201.14(a) Responsibility of licensee. Previously cited 8/29/19, 11/8/19, 12/9/19, 12/23/19, 7/23/20, 10/1/20, 12/14/20, 12/18/20, 4/28/21. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	28 Pa Code 201.18(b)(1)(e)(1) Management. 28 Pa Code 201.29(a)(j) Resident rights. 28 Pa Code 211.12(d)(1)(5) Nursing services. Previously cited 4/28/21. 28 Pa Code 211.12(d)(3) Nursing services. Previously cited 12/23/19, 12/18/20, 4/28/21.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26071 Based on review of facility policies, clinical records, incident reports, employee statements and staff interview, it was determined that the facility failed to provide adequate supervision, implement effective fall interventions and utilize a mechanical lift as per order to promote resident safety resulting in a preventable accident and actual harm to one of 10 residents (Resident R1). Findings include: A review of the facility policy Hoyer Lift-Proper Use dated 5/26/21, indicated residents who are unable to transfer themselves independently or with minimum assistance shall be transferred safely with the Hoyer lift (a mechanical lift used to transfer residents) and two nursing staff are needed to transfer a resident using a Hoyer lift. A review of the clinical record indicated Resident R1 was readmitted to the facility on [DATE], with diagnoses that included heart failure, schizophrenia (a mental disorder that causes hallucinations and delusions), history of a right hip fracture, and osteoporosis (a weakening of the bones). A review of Resident R1's quarterly MDS assessment (MDS-Minimum Data Set Assessment: periodic assessment of resident care needs) dated 5/24/21, indicated that the diagnoses remained current. A review of Resident R1's care plan dated 5/26/21, indicated that Resident R1 was at risk of falls due to weakness and deconditioning, and impaired safety awareness. Facility staff would provide Resident R1 with appropriate assistive devices for safe transfers. The care plan stated that the resident required a mechanical lift with assist of two for transfers. Review of Resident R1's physician order dated 2/18/21, indicated that Resident R1 was to be transferred with a mechanical lift. A review of incident report dated 7/4/21, indicated at 10:38 a.m. Resident R1 complained of right lower extremity pain after transfer from the bed to the wheelchair. The physician was notified and examined the resident and ordered x-rays to rule out a fracture. A review of NA Employee E1 Witness Statement dated 7/7/21, indicated that the nurse aide pivoted (stand and turned) Resident R1 from bed to chair with NA Employee E2 without using a mechanical lift. A review of NA Employee E2 Witness Statement dated 7/7/21, indicated the nurse aide did not use a lift and had a hard time getting Resident R1 into the chair and when Resident R1 was in the chair she complained that her leg was broken. A review of Resident R1's Orthopedic (medical speciality that focuses on the skeletal system) consult dated 7/6/21, indicated a closed fracture of the distal end of the right femur. A review of NA Employee E1's employee transcript dated 5/18/21, indicated she had received education on proper body mechanics and use of a mechanical lift, and she was educated on abuse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of NA Employee E2's employee transcript dated 6/29/21, indicated she received education on proper body mechanics and use of a mechanical lift, and she was educated on abuse. During an interview on 7/16/21, at 11:00 a.m. the NHA confirmed the facility's investigation of the incident found that it involved a substantiated neglect of service against NA Employee E1 and E2, as they did not use a mechanical lift as ordered to transfer Resident R1. During an interview on 7/16/21, at 10:30 a.m. NA Employee E1 stated she transferred Resident R1 without a mechanical lift because someone on the floor told her it was ok. She stated she rarely worked with Resident R1. She stated she should have checked the transfer status for Resident R1 instead of listening to someone on the floor. During an interview on 7/16/21, at 11:05 a.m. NA Employee E2 stated that Resident R1 kept saying she was a transfer with a mechanical lift, and she could not stand, but NA Employee E1 said they could transfer with a 2 person assist and it would be ok. During an interview on 7/16/21, at 10:20 a.m. Medical Director Employee E3 confirmed Resident R1 could not stand and walk prior to the incident thus, was ordered a mechanical lift for all transfers. During an interview on 7/16/21, at 2:30 p.m. the Nursing Home Administrator confirmed that the facility failed to implement effective fall interventions and utilize a mechanical lift as per physician order resulting in a preventable accident and Resident R1 suffering actual harm from a fractured right femur. 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices 28 Pa. Code 211.10(d) Resident care policies 28 Pa Code 211.12(d)(1)(2)(5) Nursing services.