STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395561	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reformed Presbyterian Home	2344 Perrysville Avenue Pittsburgh, PA 15214

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 - Minimal harm or potential for 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** Based on review of facility policy, facility submitted documents, clinical records and staff interviews, it was determined that the facility failed to make certain each resident was free from neglect by not ensuring adequate supervision and assistance for transfers for one of three residents reviewed (Resident R2).Findings include:Review of facility policy Prevention of Abuse and Response dated 7/15/25, indicated neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs on an individual basis when a resident does not receive care in one or more areas (e.g., absence of frequent monitoring for a resident known to be incontinent, resulting in being left to lie in urine or feces). Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/6/25, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and arthritis (inflammation of one or more joints, causing pain and stiffness).Review of a physician order dated 10/2/25, indicated to transfer resident with full body lift (a mechanical lift).Review of Resident R2's Kardex (a snapshot of resident care needs) dated 10/8/25, indicated the resident transfers with Hoyer/full lift and assist of two staff.Review of a progress note dated 10/8/25, stated, Resident was being transferred to bed to the w/c (wheelchair). During the transfer the Hoyer lift tilted so the CNA (Certified Nurse Aide) had to lower her to the floor. Resident was assessed. She states that she hit her head and left shoulder. When her husband came in she requested to go to the ER (emergency room) for head pain. Physician and DON (Director of Nursing) notified.Review of a witness statement dated 10/8/25, completed by Nurse Aide (NA) Employee E1 stated, On October 8th around 1:30 p. m. I got Resident R2 all cleaned up changed to get her up in the Hoyer. She was holding on and when I went to turn it towards her chair it tilted and it was falling, so I held it to slowly lower to ground.During an interview on 11/24/25, at 1:11 p.m. the Nursing Home Administrator (NHA) stated, Resident R2's spouse was pressuring NA Employee E1 to get the resident into her chair because they wanted to go outside to smoke. During an interview on 11/24/25, at 2:15 p.m. the NHA and DON confirmed that the facility failed to make certain each resident was free from neglect by not ensuring adequate supervision and assistance for transfers for Resident R2. 28 Pa. Code: 201.14(a) Responsibility of licensee28 Pa. Code: 201.18(b)(1) Management.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(5) Nursing services.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395561	A. Building B. Wing	11/24/2025

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	395561	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reformed Presbyterian Home	2344 Perrysville Avenue Pittsburgh, PA 15214

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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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, facility policy, clinical records, resident interview, and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision that resulted in an elopement (leaving an area without permission) for one of 55 residents (Resident R1).Findings include: Review of facility policy Elopement Prevention Guidelines last reviewed 7/15/25, indicated that the facility strives to promote resident safety and protect the rights and dignity of the residents. The facility maintains a process to assess all residents for risk of elopement; implement prevention strategies for those identified as elopement risk and follow a missing resident protocol. A situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision, if necessary, would be considered an elopement. Risk prevention includes:The nurse or designee will complete an elopement risk assessment for every resident upon admission, quarterly, annually, and as needed.The staff will regularly monitor the resident's whereabouts at mealtimes, medication administration and every two hours with nursing rounds. The staff will report to the Supervisor on duty, when he/she has observed resident behavior which is consistent with elopement (i.e., pacing, verbalizations of leaving the building, increased confusion, etc.). Review of Resident R1's admission record indicated she was admitted to the facility on [DATE]. Review of Resident R1's clinical record revealed an Elopement Evaluation dated 7/25/25, that did not identify resident to be at risk for elopement, Review of Resident R1's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 7/29/25, included diagnoses of high blood pressure, dysphagia (difficulty swallowing), and malnutrition (lack of nutrients in the body). Review of clinical record revealed a nursing progress note dated 11/1/25, at 5:15 p.m. that stated the following: At 17:15 (5:15 p.m.) staff noticed resident missing from her room during supper. Staff searched Dining Room and nearby bathrooms and not found. Elopement protocol initiated and nursing and one kitchen staff member searched every level of interior of building and outside front and back.17:33 (5:33 p.m.) Notified administrator.17:37 (5:37 p.m.) Called 911 and reported resident missing and answered questions about the resident's previous addresses, friends, family, possible whereabouts.18:11 (6:11 p.m.) Notified resident's son and received info re. [regarding] resident's prior conversations with her son as well as prior addresses where she lived.18:30 (6:30 p.m.) Police arrived and officer spoke with staff as well as resident's roommate then left building after they were completed.18:49 (6:49 p.m.) Received recent photos via email from resident's son.19:07 (7:07 p.m.) Called 911 and shared info re. prior addresses and info received from son.19:29 (7:29 p.m.) Received call from police asking if resident had a cell phone which she doesn't or if she does have one is not functioning.20:35 (8:35 p.m.) Resident returned to building assisted by laundry staff member (Laundry Worker (LW) Employee E2) who spotted resident downtown and aided her by getting on bus with her and bringing her back here. Notified 911 of resident's return and other staff notified Administrator as well as resident's son. 20:40 (8:40 p.m.) Notified doctor's group and spoke with Certified Registered Nurse Practitioner who OK'd sending resident to ER [Emergency Room] for medical evaluation to make sure no injury occurred while she was away from facility today. Went back to get resident who absolutely refused to go. Police returned at this point and witnessed that resident denied having any pain or injury and refused to go to ER. After police left this nurse checked resident from head to toe and found no bruises, no swelling and all skin noted to be intact. Offered resident food/fluids and nurse aide will be assisting resident to bed when resident was ready to go to bed. Review of facility document Summary of Events dated 11/1/25, stated the following:17:55 (5:55 p.m.) Administrator confirms resident left the building using camera system. Resident ambulating safely and with recommended device (standard wheeled walker)Details of the camera system revealed the following13:14 (1:14 p.m.) Resident witnessed getting on the elevator from 3rd floor13:14 (1:14 p.m.) Resident was observed in main reception13:16 (1:16 p.m. Resident observed leaving out the front entrance ambulating with wheeled walker. Resident gets on Bus 6357 8 downtown. Review of a written statement from LW Employee E2 dated 11/1/25, stated Resident was downtown. She got on the number 8 bus. To the best of my knowledge, she was headed back (to the facility). She was unsure of her directions, so I decided to get off the bus together and escort her back into (the facility) from the bus stop up to the 3rd floor. During an interview on 11/24/25, at 10:40 a.m. Resident R1 confirmed that she had left the faciity on [DATE], and asked Are they still talking about that? I went to my apartment to get shoes and jacket. I got them then I got confused on how to get back. Then I saw [LW Employee E2] who got me on the right bus and brought me back. During an interview