

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024
NAME OF PROVIDER OR SUPPLIER Pittsburgh Skilled Nursing and Rehabilitation Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 550 South Negley Avenue Pittsburgh, PA 15232	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>27424</p> <p>Based on resident and staff interviews and review of facility documentation it was determined that the facility failed to offer all residents the opportunity to vote for May and November of 2023.</p> <p>Findings include:</p> <p>Review of Resident Council minutes for six months (March, February, January 2024, and December, November, and October 2023) failed to include information about how the facility ask's residents if they are interested in voting.</p> <p>During a resident group on 4/ 9/24, at 2:30 p.m. two residents said they were unaware of voting for May and November of 2023 elections. Both of the residents said they were interested in voting.</p> <p>During an interview on 4/10/24, at 12:51 p.m. Nursing Home Administrator confirmed that the facility failed to have documentation showing that all residents were offered the opportunity to vote for May and November of 2023 elections.</p> <p>28 Pa. Code 201.1(i) Resident rights.</p>

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
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27424</p> <p>Based on observation, and staff interview, it was determined the facility failed to maintain a clean homelike environment for two of three floors (1st floor and 3rd floor).</p> <p>Findings Include:</p> <p>Review of the facility policy Resident Rights Under Federal law last reviewed 11/1/23, indicated the residents have the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safety. The facility must provide housekeeping and maintenance services necessary to maintain sanitary, orderly, an comfortable interior.</p> <p>During a tour of the 1 North Nursing Unit on 4/9/24, starting at 1:15 p.m., with Nursing Home Administrator (NHA), the following was observed:</p> <p>At 1:15 p.m., Resident R91's room [ROOM NUMBER]B had crumbling wall surface damage under window, above heating unit.</p> <p>At 1:19 p.m., Resident R123's room [ROOM NUMBER]A had white chips and gouges in the wall behind her bed.</p> <p>At 1:20 p.m., Resident R117's room [ROOM NUMBER]B had white chips and gouges in the wall behind her bed, and crumbling wall surface damage under the window, above heating unit.</p> <p>At 1:25 p.m., Resident R6's room [ROOM NUMBER]A had a phone jack connection panel hanging out of the wall, with interior wiring exposed.</p> <p>During an additional tour of 1 North Nursing Unit on 4/10/24, at 9:45 a.m., with NHA, the following was observed:</p> <p>Resident R36's room [ROOM NUMBER]A had a 2 foot wide, by 6 inch high hole in the wall behind her bed above the cove base, with broken plaster pieces and interior brick structure exposed.</p> <p>During an interview on 4/10/24, at 9:50 a.m., NHA confirmed that the facility failed to maintain a clean and homelike environment for the 1 North Nursing unit.</p> <p>Observation 4/8/24, at 9:35 a.m. the main elevator door grates full of debris and grime.</p> <p>Observation on 4/8/24, at 9:40 a.m. the Shower Room on One Pavilion was missing a door handle. There was a large circular opening where the door knob should have been.</p> <p>Observation on 4/8/24, at 9:41 a.m. Resident R5's (room [ROOM NUMBER]) door frame had wall paper peeling with a yellow gray substance underneath. The base board was missing.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 4/8/24, at 9:44 a.m. the Nursing Home Administrator confirmed the above findings.</p> <p>Observation on 4/9/24, at 10:15 a.m. Resident R13's (room [ROOM NUMBER]) floor was covered in grime and debris that appeared sticky.</p> <p>Observation on 4/9/24, at 10:16 a.m. room [ROOM NUMBER]'s floor was covered in debris, food particles, and grime.</p> <p>Observation on 4/9/24, at 10:17 a.m. Resident R10's (room [ROOM NUMBER]) floor was covered in debris and grime.</p> <p>Interview on 4/9/24, at 10:19 a.m. Environmental Services Director Employee E11 confirmed the rooms [ROOM NUMBER] floors were unkempt and did not appear clean.</p> <p>During a tour of the 3rd floor secured unit starting at 10:01 a.m. the following was observed:</p> <p>04/11/24 10:05 AM 333 - marks on closet door / hole in bathroom door / chipping behind bed</p> <p>04/11/24 10:07 AM 319 - holes in socket behind bed</p> <p>04/11/24 10:09 AM 334 extension cord behind TV, chip in wall by TV / base boards with scuffs / chip by door / air unit dirt/ debis</p> <p>04/11/24 10:11 AM hallway open phone jack/ holes in wall above open phone jack</p> <p>04/11/24 10:12 AM 321 dirt /debis air unit and wall by window</p> <p>04/11/24 10:13 AM lounge open switch plate lounge air units are dirty /plug cover aren't flushed to the wall /H2O bubble in corner of lounge / furniture (chairs) with rips in the seating, couch with rips in the arms</p> <p>04/11/24 10:19 AM 338 base boards with scuffs dirt/debris / cracked window sill</p> <p>04/11/24 10:20 AM 339 window sill cracked /window no screen /dirt/debis in air unit</p> <p>04/11/24 10:27 AM open socket down short hall</p> <p>04/11/24 10:29 AM 329 air unit dirty/debris/window sill cracked, rust in bathroom on corners</p> <p>04/11/24 10:30 AM 330 dirt / debris in air unit /window sill crack</p> <p>04/11/24 10:31 AM ripped furniture in lounge / no furniture in dining room</p> <p>04/11/24 10:31 AM no seating was observed in the dining room with few dining tables available for residents to sit during meals.</p> <p>Interview on 4/12/24, at 11:16 a.m. NHA confirmed that the facility failed to maintain a clean homelike environment.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 4/12/24, at 2:40 p.m. the Nursing Home Administrator confirmed the facility failed to maintain a clean homelike environment for two of three floors (1st floor and 3rd floor).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>27424</p> <p>Based on review of investigative documents and staff interview it was determined that the facility failed to prevent neglect with an unlicensed employee provided a non-ordered medication to a resident for one of one resident (Resident R62).</p> <p>Findings include:</p> <p>PA state Regs define Nurse Aids as an individual, as defined in 42 CFR 483.5, providing nursing or nurse related services to residents in a facility who: Does not have a license to practice professional or practical nursing in this Commonwealth. Does not volunteer services for no pay. Has met the requisite training and competency evaluation requirements as defined in 42 CFR 483.75 (relating to administration).</p> <p>Review of facility documentation submitted to the State Survey Agency indicated: NA (Nurse Aide) Employee E19 was accused of administering medication (melatonin) to Resident R62. NA Employee E19 was called into the facility for the purpose of providing a statement related to the accusation of alleged medication abuse. At that time NA Employee E19 admitted fault in regards to administering personal supply of medication to Resident R62.</p> <p>During an interview on 4/12/24, at 11:46 a.m. NHA (Nursing Home Administrator) confirmed that the facility failed to prevent neglect with an unlicensed employee provided a non-ordered medication to a resident for one of one resident (Resident R62).</p> <p>28 Pa. Code201.18(e)(1)Management.</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on facility policy, clinical record review and interview with facility staff, it was determined that the facility failed to obtain a physician order for residents transferred to an acute care facility for two of three residents (Resident R10 and R126).</p> <p>Findings include:</p> <p>Review of the facility policy Discharge and Transfer dated 11/1/23, indicated the Center must immediately inform the patient/patient representative, consult with the patient's physician, and notify consistent with below when there is a decision to transfer or discharge the patient from the Center. The transfer or discharge is necessary for the patient's welfare and the patient's needs cannot be met be the Center.</p> <p>Review of the clinical record indicated Resident R10 was admitted to the facility on [DATE], with diagnoses that included diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), high blood pressure, and depression. Review of the Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/24/24, indicated the diagnoses remained current.</p> <p>Review of a progress note dated 3/29/24, at 11:20 a.m. indicated a new order was received for Resident R10 to be sent to the hospital for low blood glucose and decreased responsiveness.</p> <p>Review of Resident R10's physician orders failed to include a physician order to send the resident to the acute care facility on 3/29/24.</p> <p>Review of the clinical record indicated Resident R126 was admitted to the facility on [DATE], with diagnoses that included osteomyelitis of right ankle and foot (inflammation of bone or marrow, usually due to infection), peripheral vascular disease (a condition in which narrowed blood vessels reduce blood flow to the limbs), and heart failure (heart doesn't pump blood as well as it should).</p> <p>Review of a progress note dated 1/2/24, at 3:23 p.m. indicated a new order was received for Resident R126 to be sent to the emergency room due to lethargy.</p> <p>Review of Resident R126's physician orders failed to include a physician order to send the resident to the acute care facility on 1/2/24.</p> <p>Interview on 4/11/24, at 10:38 a.m. the Director of Nursing confirmed facility failed to obtain a physician order for residents transferred to an acute care facility for two of three residents reviewed (Resident R10 and R126).</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on clinical record review and interview with facility staff, it was determined that the facility failed to provide a notice of bed hold policy for residents transferred to an acute care facility for two of three residents reviewed (Resident R10 and R126).</p> <p>Findings include:</p> <p>Review of the facility policy Bed-Holds dated 11/1/23, indicated when a resident is transferred out of the service location to a hospital, the designee will provide the resident with the written Bed Hold Policy Notice & Authorization form regardless of the payer.</p> <p>Review of the clinical record indicated Resident R10 was admitted to the facility on [DATE], with diagnoses that included diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), high blood pressure, and depression. Review of the Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/24/24, indicated the diagnoses remained current.</p> <p>Review of a progress note dated 3/29/24, at 11:20 a.m. indicated a new order was received for Resident R10 to be sent to the hospital for low blood glucose and decreased responsiveness.</p> <p>The clinical record did not include a written Bed Hold Policy Notice & Authorization form as required.</p> <p>Review of the clinical record indicated Resident R126 was admitted to the facility on [DATE], with diagnoses that included osteomyelitis of right ankle and foot (inflammation of bone or marrow, usually due to infection), peripheral vascular disease (a condition in which narrowed blood vessels reduce blood flow to the limbs), and heart failure (heart doesn't pump blood as well as it should).</p> <p>Review of a progress note dated 1/2/24, at 3:23 p.m. indicated a new order was received for Resident R126 to be sent to the emergency room due to lethargy.</p> <p>The clinical record did not include a written Bed Hold Policy Notice & Authorization form as required.</p> <p>Interview on 4/11/24, at 10:14 a.m. the Nursing Home Administrator confirmed the notices above were not present.</p> <p>Interview on 4/12/24, at 2:40 p.m. the Nursing Home Administrator confirmed the facility failed to provide a notice of bed hold policy for residents transferred to an acute care facility for two of three residents reviewed (Resident R10 and R126).</p> <p>28 PA Code: 201.29(j) Resident rights.</p> <p>28 Pa. Code 201.20(a)(b)(c)(d) Staff Development.</p> <p>(continued on next page)</p>		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code: 201.14 (a) Responsibility of licensee 28 Pa Code: 201.18 (b)(1) Management.

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on a review of facility policy and clinical records and staff interviews it was determined that the facility failed to make certain that resident assessments were accurate for one of three hospice residents (Resident R30).</p> <p>Findings include:</p> <p>Review of the Resident Assessment Instrument (RAI) Manual (provides instructions and guidelines for completing a Minimum Data Set Section (MDS-periodic assessment of care needs) dated October 2023, Section O: Special Treatments, Procedures, and Programs. The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received or performed during the specified time periods. Code residents identified as being in a hospice program for terminally ill persons.</p> <p>Review of the admission record indicated Resident R30 was admitted to the facility on [DATE].</p> <p>Review of Resident R30's MDS dated [DATE], indicated the diagnoses of stroke (damage to the brain from an interruption of blood supply), hemiplegia (paralysis of one side of the body), and metastatic (cancer has spread beyond the prostate) prostate cancer.</p> <p>Review of Resident R30's physician order summary indicted an order dated 3/4/23, for hospice care.</p> <p>Review of Resident R30's care plan dated 1/25/24, indicated the resident is under hospice care for terminal prostate cancer.</p> <p>Further review of Resident R30's MDS dated [DATE], Section O failed to indicate hospice services as required.</p> <p>Interview on 4/12/24, at 11:02 a.m., the Director of Nursing confirmed Resident R30's MDS dated [DATE], Section O failed to indicate hospice as required, and the facility failed to make certain that resident assessments were accurate for one of three hospice residents (Resident R30).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on review of facility policy, resident group interviews, resident interview and observations, clinical record review, and staff interview it was determined that the facility failed to provide Activity of Daily Living (ADL) assistance for two of five residents (Resident R26 and R45).</p> <p>Findings include:</p> <p>Interview of the Resident Group on 4/9/24, at 2:00 p.m. indicated the residents had concerns regarding getting out of bed, and assistance with showers and bathing.</p> <p>Review of the facility policy Activities of Daily Living dated 11/1/23, indicated the Center must provide the necessary care and services to ensure that a patient's activities of daily living (ADL) abilities are maintained and provided in accordance with accepted standards of practice, the care plan, and the patient's choices and preferences.</p> <p>Review of admission record indicated Resident R26 was admitted to the facility on [DATE].</p> <p>Review of Resident R26's Minimum Data Set (MDS- a periodic assessment of care needs) dated 2/2/24, indicate the diagnoses of heart failure (heart doesn ' t pump blood as well as it should), high blood pressure, and hemiplegia (paralysis of one side of the body). The Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact. Resident's score was 13.</p> <p>Section GG indicated resident is dependent for bed to chair transfers and requires substantial/maximal assistance with bathing and hygiene.</p> <p>Review of Resident R26's care plan dated 3/1/24, indicated to assist with daily hygiene, grooming, dressing, oral care and eating as needed, and the resident transfers with the assist of two people and the use of Hoyer lift (a machine that lifts a body from point A to point B).</p> <p>Observations on 4/8/24, at 11:15 a.m. Resident R26 was in bed, under covers in a night gown.</p> <p>Interview on 4/8/24, at 11:15 a.m. resident indicated he hasn't been washed up yet today and wanted out of bed early in the morning.</p> <p>Observation on 4/9/24, at 12:52 a.m. resident in bed eating lunch, dressed. Stated They said they'd get me after lunch.</p> <p>Observation on 4/10/24, at 1:27 p.m. resident in bed in gown.</p> <p>Interview on 4/10/24, at 1:28 p.m. Registered Nurse (RN) Employee E8 verified resident was still in bed and indicated it's a challenge to get to everyone the way they assignments are set up.</p> <p>Review of admission record indicated Resident R45 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R45's MDS dated [DATE], indicate the diagnoses of Non-Alzheimer's Dementia (condition where memory loss and signs of Parkinson's disease {tremors} present together), left eye blindness, and high blood pressure. Section C indicated resident had moderately impaired cognitive ability with a BIMS score of ten. Section GG indicated Resident R45 required setup or clean-up assistance. Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.</p> <p>Review of Resident R45's care plan dated 1/25/24, indicated resident will be clean, dressed, and well-groomed daily to promote dignity and psychosocial wellbeing. Assist with daily hygiene, grooming, dressing, oral care and eating as needed. Impaired vision, will have ADL needs met with staff assistance as needed.</p> <p>Observation on 4/10/24, at 11:06 a.m. Resident R45's room indicated an unmade bed, with top sheet at foot of bed presenting with brown substance and 8 gnats on the sheet and a few flying about it.</p> <p>Interview on 4/10/24, at 11:07 a.m. RN Employee E7 confirmed the above observation.</p> <p>Observation on 4/10/24, at 11:15 a.m. Resident R45 was observed coming off the elevator in her wheelchair. [NAME] tennis shoes bilaterally (both sides) have brown substance dried on tops and sides of the shoe and the right lower calf of her leg had dried brown substance on it.</p> <p>Interview on 4/10/24, at 11:16 a.m. the Director of Nursing confirmed Resident R45's appearance.</p> <p>Interview on 4/10/24, at 2:00 p.m. the Director of Nursing confirmed the facility to provide ADL assistance for two of five residents (Resident R26 and R45).</p> <p>28 PA Code: 201.29(j) Resident rights.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>27424</p> <p>Based on observations, review of the Activity Calendars for two six months and staff interview, it was determined that the facility failed to provide an ongoing program of activities to meet resident needs designed and based on the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.</p> <p>Findings include:</p> <p>During a group on 4/9/24, at 2:15 p.m. Residents stated that the activities do not meet their needs, Residents stated that they wanted outside activities such as shopping trips, restaurants, going to the park, etc. Residents indicated that they have not had an outside activity for over a year. Resident indicated that they wanted different activities in the facility to include , different games,(card, Olympic style theme games, etc.), and they wanted to do activities on the facility grounds but outside in the courtyard or activities like cookouts/picnics.</p> <p>Review of the facility activity calendar failed to include the above mentioned games of: shopping trips, restaurants, going to the park, etc. Residents indicated that they have not had an outside activity for over a year. Resident indicated that they wanted different activities in the facility to include , different games,(card, Olympic style theme games, etc.), and they wanted to do activities on the facility grounds but outside in the courtyard or activities like cookouts/picnics.</p> <p>Observations on the secured unit from April 10th, 11th, and 12th failed to include any of the activities on the April calendar.</p> <p>During interviews with staff on the secured unit there were three activities listed as being done with residents : played Elvis music, activity centered around Easter, and an art activity. Review of the activity calendar failed to include these activities or clarify what and which activities residents in the secured unit were offered.</p> <p>During an interview on 4/12/24, at 11:19 a.m. NHA (Nursing Home Administrator) confirmed that the facility failed to provide an ongoing program of activities to meet resident needs designed and based on the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.</p> <p>28 Pa. Code:201.18(b)(3)Management.</p> <p>28 Pa. Code:207.2(a)Administrators Responsibility.</p>

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<p>F 0680</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the activities program is directed by a qualified professional.</p> <p>27424</p> <p>Based on review of facility documentation, and staff interview it was determined that the facility failed to ensure that the Activities Department had a qualified director to oversee the activities program.</p> <p>Findings include:</p> <p>Review of the Director of Recreation Services indicated The Director of Recreation Services is responsible for the development, implementation and supervision of the full scope of recreation services in the nursing center. Ensures that recreations services are in compliance with policies and procedures and federal/state regulations.</p> <p>Review of the Director of Recreation Services on 4/11/24, at 1:27 p.m. personnel file Employee E20 personnel file did not include information regarding the Director of Recreation Services having completed a state approved program to be qualified to oversee the Activity Program.</p> <p>During an interview on 4/12/24, at 11:19 a.m. Nursing Home Administrator confirmed that the Director of Recreational Services has not completed a state approved program to be qualified to oversee the Activity Program.</p> <p>28 Pa. Code:201.18(b)(3)Management.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to follow physician's orders and notify the physician of decreased blood pressures for one of three residents (Resident R11) and failed to provide timely care and services for two of four residents (Resident R11 and R87) requiring dental services.</p> <p>Findings include:</p> <p>Review of facility policy Physician/Advanced Practitioner Provider (APP) Notification dated 1/11/23, indicated upon identification of a patient who has a change in condition, abnormal laboratory values, or abnormal diagnostics, a licensed nurse will report to the physician/APP. If unable to contact attending physician/APP, the Medical Director will be contacted.</p> <p>Review of facility policy Dental Services dated 11/1/23, indicated centers will provide or obtain from an outside resource routine and emergency dental services, including 24-hour emergency dental care, to meet the needs of each patient.</p> <p>Review of the clinical record indicated Resident R11 was admitted to the facility on [DATE].</p> <p>Review of Resident R11's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/1/24, indicated diagnoses of renal failure (one or both kidneys cannot function on their own), orthostatic hypotension (low blood pressure that happens when standing up from sitting or lying down, hemiplegia (paralysis on one side of the body).</p> <p>Review of a physician order dated 1/4/24, indicated to monitor vital signs every shift and notify provider of a systolic blood pressure (measurement of pressure in arteries when the heart beats) less than 95 mmHg (millimeters of mercury) or greater than 180 mmHg.</p> <p>Review of Resident R11's March 2024 Treatment Administrator Record (TAR) indicated 14 instances when Resident R11's systolic blood pressure was less than 95 mmHg or not documented. 11 of these instances were not reported to the physician as ordered.</p> <p>During an interview on 4/11/24, at 12:14 p.m. the Registered Nurse Clinical Lead PA [NAME] Employee E10 confirmed that the facility failed to follow physician's orders and notify the physician of decreased blood pressures for Resident R11.</p> <p>During an interview on 4/9/24, at 9:20 a.m. Resident R11 stated that she was having right upper gum pain and that she would like to have her broken tooth pulled. Resident R11 stated that this pain has been going on for, a while.</p> <p>Review of a Progress Note dated 2/7/24, completed by the Certified Registered Nurse Practitioner (CRNP) stated, Patient tried to open a can of soda with her teeth and broke her right upper tooth yesterday.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a physician order dated 2/7/24, indicated to consult an outside service dentist for right upper tooth fracture.</p> <p>Review of a physician order dated 3/26/24, indicated to consult with dental, patient wishes to have several teeth extracted.</p> <p>Review of a physician order dated 4/9/24, indicated to consult dental for potential gum infection/pain.</p> <p>Review of a Summary Report dated 3/12/24, completed by an outside service dentist stated, Resident was diagnosed with a potential need to consult with an Oral Maxillofacial Surgeon (OMS). An internal case review will be completed to determine if treatment can be completed in the facility or will need to be referred to OMS. Resident potentially has extractions that are surgical in nature. Resident has multiple teeth that need to be removed in 4-6 areas of the oral cavity.</p> <p>Review of a Physician Clearance for Dental Treatment form was completed and dated 4/11/24, by the CRNP for Resident R11.</p> <p>During an interview on 4/11/24, at 1:59 p.m. the Director of Nursing (DON) stated that the facility received the Physician Clearance for Dental Treatment form on 3/28/24. The DON stated, The form was flagged on Resident R11's chart and I had the CRNP fill it out today.</p> <p>During an interview on 4/11/24, at 2:01 p.m. the DON confirmed that Resident R11's Physician Clearance for Dental Treatment form was flagged on the resident chart and unaddressed by a physician or advanced practitioner from 3/28/24, to 4/11/24.</p> <p>Review of the clinical record indicated Resident R87 was admitted to the facility on [DATE].</p> <p>Review of Resident R87's MDS dated [DATE], indicated diagnoses of stroke (damage to the brain from an interruption of blood supply), hemiplegia, and high blood pressure.</p> <p>Review of Resident R87's physician orders dated 3/21/24, indicated Augmentin (antibiotic for infection) twice a day for 14 days for dental abscess.</p> <p>Further review of the clinical record revealed Resident R87 was seen by the dentist on 3/12/24, which indicated a potential need to consult with an oral maxillofacial surgeon (surgeon specializes in diagnosis and treatment of mouth, jaws, face, and neck). Resident potentially has extractions (teeth removal) that are surgical in nature. Resident has multiple teeth that need to be removed in four to six areas of the oral cavity.</p> <p>Interview with the Director of Nursing on 4/11/24, at 11:45 a.m. indicated Resident R87's teeth got bad quickly because since his stroke, he's grinding his teeth.</p> <p>Additional review of the record indicated on 5/4/23, the physician's note indicated patient expressing concern in regard to tooth decay and grinding teeth. Consult placed for dental evaluation for caries (permanently damaged areas in teeth that develop into tiny holes) and decay.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the physician's note dated 11/6/23, indicated resident grinding his teeth and asks for a mouth guard. Consult placed for dental evaluation for caries and decay.</p> <p>Review of Dental Summary Report for Resident R87 dated 9/1/23 - 4/12/24 indicated on 9/26/23, resident was not seen as he refused.</p> <p>Review of progress notes from 3/12/24 - 3/21/24 indicated no additional measures were implemented prior to the dental abscess forming and after the dentist recommended surgery.</p> <p>Review of practitioner's note dated 3/21/24, indicated right jaw with significant swelling. Swelling inside mouth near a decayed tooth. Urgent dental consult put in for possible extraction/evaluation of decayed tooth. Scheduling department to schedule.</p> <p>Interview with the Director of Nursing on 4/12/24, at 11:30 a.m. indicated resident never had a mouth guard and could not provide any proof of intervention between 3/12/24, dental report and 3/21/24, physician orders for antibiotic treatment of the abscessed teeth.</p> <p>Interview on 4/12/24, at 2:40 p.m. the Director of Nursing confirmed the facility failed to follow physician's orders and notify the physician of decreased blood pressures for one of three residents (Resident R11) and failed to provide timely care and services for two of four residents (Resident R11 and R87) requiring dental services.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1)(3) Management.</p> <p>28 Pa. Code 201.29(a)(c)(d)(j) Resident Rights.</p> <p>28 Pa. Code 211.10(c)(d) Resident Care Policies.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27424</p> <p>Based on review of clinical records, and staff interview it was determined that the facility failed to make certain that residents were monitored, assessed and received the necessary services to prevent pressure ulcers from developing or worsening for one of five residents (Resident R23).</p> <p>Findings include:</p> <p>Review of the clinical record indicated Resident R23 was admitted to the facility on [DATE].</p> <p>Review of Resident R23 Minimum Data Set (MDS- a periodic assessment of resident needs) dated 2/17/24, indicated diagnoses of neurogenic bladder (person lacks bladder control), diabetes (condition that affects how your body turns food into energy) and anxiety disorder (excessive worry).</p> <p>Review of facility documentation indicated Resident R23 had the following wounds:</p> <p>Right Knee stage 3 - start date 11/16/23</p> <p>Right Heel Unstageable - start date 11/21/23</p> <p>Right Hip Stage 4 - start date 1/4/24</p> <p>Left Lateral Leg Stage 3 - start date 11/30/23</p> <p>Left Heel unstageable - 11/30/23</p> <p>Sacrum stage 2 - 11/21/23</p> <p>Left lateral foot stage 4 - 11/30/23</p> <p>Review of the physician orders failed to include preventive measures to include a specific type of mattress for healing, off-loading on a pillow, specialized boots (footwear to relieve pressure while residents are in bed), etc. for Resident R23.</p> <p>Review of facility MAR/TAR (Medication Administration Record/Treatment Administration Record) for April and March 2024 failed to include preventive measures for the seven wounds.</p> <p>During an interview on 4/12/24, at 9:43 a.m. Registered Nurse (RN) Employee E21 confirmed that the physician orders did not contain preventive measures and that the MAR/TAR for April and March 2024 and the facility failed to monitor, assess and pressure ulcer wounds.</p> <p>28 Pa. Code:211.10(a)(C)(d) Resident care polices.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577</p> <p>Based a review of facility policy, clinical record review and staff interview, it was determined that the facility failed to timely assess the nutritional status for four of five resident (Resident R1, R24, R25, and R82) records reviewed .</p> <p>Findings include:</p> <p>Review of facility policy Nutrition Care Process, dated 11/1/23, indicated Residents are assessed upon admission and routinely thereafter. Nutrition assessment is completed by the Dietitian or the non-dietitian designee upon admission and with changes in nutritional status. Generally, a nutrition assessment is completed in conjunction with a MDS 3.0 OBRA assessment.</p> <p>Review of Resident R1's admission record indicated that she was admitted to the facility 3/16/11.</p> <p>Review of Resident R1's Minimum Data Set (MDS) assessment (mandated assessment of a resident's abilities and care needs) dated 3/8/24, indicated diagnoses of epilepsy (a neurological disorder that causes seizures or unusual sensations and behaviors), breast cancer, and depression.</p> <p>Review of Resident R1's MDS assessment dated [DATE], indicated in Section K0520: Nutritional Approaches, therapeutic diet was checked, indicating that While a Resident in the past 7 days, this nutritional approach was performed.</p> <p>Review of Resident R1's clinical record failed to reveal nutritional assessment documentation addressing her nutritional status and therapeutic diet captured by MDS dated [DATE].</p> <p>Review of Resident R24's admission record indicated that she was admitted to the facility 5/5/21.</p> <p>Review of Resident R24's Minimum Data Set (MDS) assessment dated [DATE], indicated diagnoses of high blood pressure, diabetes mellitus (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and cerebral infarction (a brain lesion in which a cluster of brain cells die when they don't get enough blood).</p> <p>Review of Resident R24's MDS assessment dated [DATE], indicated in Section K0520: Nutritional Approaches, feeding tube was checked, and therapeutic diet was checked, indicating that While a Resident in the past 7 days, these nutritional approaches were performed.</p> <p>Review of Resident R24's clinical record failed to reveal nutritional assessment documentation addressing her nutritional status, feeding tube, and therapeutic diet captured by MDS dated [DATE].</p> <p>Review of the clinical record indicated Resident R25 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R25's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/1/24, indicated diagnoses of Multiple Sclerosis (an autoimmune disease that affects central nervous system when the immune system attacks the protective layer around nerve fibers and causes Inflammation and lesions making it difficult for the brain to send signals to rest of the body), dysphagia (difficulty swallowing), and failure to thrive (a syndrome of decline in older adults that affects their physical, mental, and social well-being).</p> <p>Review of Resident R25's MDS assessment dated [DATE], indicated in Section K0520: Nutritional Approaches, mechanically altered diet was checked, indicating that While a Resident in the past 7 days, this nutritional approach was performed.</p> <p>Review of Resident R25's clinical record failed to reveal nutritional assessment documentation addressing her nutritional status and mechanically altered diet captured by MDS dated [DATE].</p> <p>Review of the clinical record indicated Resident R82 was admitted to the facility on [DATE].</p> <p>Review of Resident R82's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/8/24, indicated diagnoses of Alzheimer's disease (a neurodegenerative disease that cause problems with memory, thinking, and behavior), dysphagia (difficulty swallowing), and aphasia (a comprehension and communication (reading, speaking, or writing) disorder resulting from damage or injury to the specific area in the brain).</p> <p>Review of Resident R82's MDS assessment dated [DATE], indicated in Section K0520: Nutritional Approaches, feeding tube was checked and mechanically altered diet was checked, indicating that While a Resident in the past 7 days, these nutritional approaches were performed.</p> <p>Review of Resident R82's clinical record failed to reveal nutritional assessment documentation addressing her nutritional status, feeding tube, and mechanically altered diet captured by MDS dated [DATE].</p> <p>During an interview on 4/11/24, at 10:45 a.m., Nursing Home Administrator (NHA) and Registered Dietitian (RD) Employee E12 confirmed that the facility failed to timely assess the nutritional status for four of five resident (Resident R1, R24, R25, and R82) records reviewed.</p> <p>28 Pa. Code: 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577</p> <p>Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure that residents who were receiving enteral feedings (nutrition through a tube) received appropriate treatment and services to prevent potential complications for two of three residents (Resident R25 and R83) and failed to follow physician's orders for one of three residents (Resident R83) receiving medications through an enteral feeding tube.</p> <p>Findings include:</p> <p>Review of facility policy Enteral Management last reviewed 11/1/23, indicated enteral tubes will be used under appropriate conditions, and those who are fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, and metabolic abnormalities. Nursing must take a baseline measurement of the tube and document it prior to using it for feeding or medication administration.</p> <p>Review of Title 42 Code of Federal Regulations (CFR) S483.25(g) indicated an enteral feeding tube may be associated with significant complications, including aspiration (when food or liquid goes into the airway instead of stomach). Aspiration risk may potentially be affected by factors such as diminished level of consciousness and improper positioning of the resident during administration of the feeding.</p> <p>Review of the clinical record indicated Resident R25 was admitted to the facility on [DATE].</p> <p>Review of Resident R25's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/1/24, indicated diagnoses of Multiple Sclerosis (an autoimmune disease that affects central nervous system when the immune system attacks the protective layer around nerve fibers and causes Inflammation and lesions making it difficult for the brain to send signals to rest of the body), dysphagia (difficulty swallowing), and failure to thrive (a syndrome of decline in older adults that affects their physical, mental, and social well-being).</p> <p>Review of Resident R25's current physician orders on 4/10/24, indicated an enteral feeding order for nutrition support of Jevity 1.5 (enteral nutritional formula) at goal rate of 85 ml/hr (milliliters per hour) x 12 hours/day until 1020 ml (milliliters) infuses, start at 20:00 hr (8:00 p.m.).</p> <p>Review of current care plan, update 4/4/24, indicated a potential for complications of feeding tube, that Resident R25 will have no complications related to tube feeding or presence of tube feeding, with interventions to administer tube feeding formula, hydration, and flushes per order; check placement and residuals per guidelines or physician order; elevate head-of-bed 30-45 degrees; and provide care of ostomy site per orders.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of current physician orders on 4/10/24, failed to indicate physician orders for aspiration precautions to include head-of-bed to be elevated 30-45 degrees, checking gastric residual volume, care of the feeding tube, feeding tube replacement, and volume of water flushes before and after medication administration via feeding tube.</p> <p>During an interview on 4/10/24, at 1:45p.m., Registered Nurse Clinical Lead PA [NAME] Employee E10 indicated that Resident R25 did not have the appropriate physician orders for nursing care regarding enteral feedings, confirming that the facility failed to ensure that residents who receive enteral feedings received appropriate treatment and service to prevent potential complications for Resident R25.</p> <p>Review of the clinical record indicated Resident R83 was admitted to the facility on [DATE].</p> <p>Review of Resident R83's MDS dated [DATE], indicated diagnoses of high blood pressure, dysphagia (difficulty swallowing), and depression (a constant feeling of sadness and loss of interest).</p> <p>Review of a physician order dated 4/9/24, indicated to administer Osmolite 1.5 (enteral nutrition formula) at 45 mL/hour x 8 hours/day until 360 mL infuses start at 8:00 p.m. through the gastrostomy tube (G-tube, a tube inserted through the abdominal wall for the purpose of administering medications and nutrition).</p> <p>Review of Resident R83's care plan on 4/10/24, indicated a potential for complications of feeding tube use and that Resident R83 will have no complications related to the presence of the feeding tube. Interventions include administer tube flushes per order and check tube placement and residuals per guideline or physician order.</p> <p>Review of current physician orders on 4/10/24, failed to indicate physician orders for aspiration precautions to include head-of-bed to be elevated 30-45 degrees, checking gastric residual volume, care of the feeding tube, feeding tube replacement, and volume of water flushes before and after medication administration via feeding tube.</p> <p>During an interview on 4/10/24, at 1:45p.m. Registered Nurse Clinical Lead PA [NAME] Employee E10 indicated that Resident R83 did not have the appropriate physician orders for nursing care regarding enteral feedings, confirming that the facility failed to ensure that residents who receive enteral feedings received appropriate treatment and service to prevent potential complications for Resident R83.</p> <p>Review of Resident R83's active physician orders on 4/10/24, indicated to administer medications via gastrostomy tube.</p> <p>During an interview on 4/10/24, Licensed Practical Nurse (LPN) Employee E15 stated, Resident R83 takes his medications by mouth crushed in applesauce. He does have one medication that we can't crush and he has to take it whole by mouth.</p> <p>During an interview on 4/10/24, at 2:11 p.m. Resident R83 stated, The nurses give me my medications crushed in applesauce, I take them by mouth. They do not give me my medications through my G-tube.</p> <p>(continued on next page)</p>		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>During an interview on 4/10/24, at 3:15 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to follow physician's orders for one of three residents (Resident R83) receiving medications through an enteral feeding tube.</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p> <p>28 Pa. Code: 211.12(d)(1) Nursing services.</p> <p>28 Pa. Code: 211.10(c) Resident care policies.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024
NAME OF PROVIDER OR SUPPLIER Pittsburgh Skilled Nursing and Rehabilitation Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 550 South Negley Avenue Pittsburgh, PA 15232	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for three of three residents (Resident R9, R13, and R45).</p> <p>Findings include:</p> <p>Review of facility policy Oxygen: Nasal Cannula dated 11/1/23, indicated to replace the disposal oxygen set-up every seven days and to date and store cannula in a treatment bag when not in use. If a humidifier is used, label with date.</p> <p>Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE].</p> <p>Review of Resident R9's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/11/24, indicated diagnoses of high blood pressure, diabetes (too much sugar in the blood), and asthma (a condition where the airways narrow and swell).</p> <p>Review of a physician order dated 12/12/23, indicated to administer oxygen at 2 liters via nasal cannula (a lightweight tube placed in the nostrils to provide oxygen) continuously.</p> <p>Review of a physician order dated 12/26/23, indicated to change oxygen tubing weekly, label each component with date, and initials every Thursday night shift.</p> <p>During an observation on 4/8/24, at 1:38 p.m. Resident R9 was observed lying in bed with her nasal cannula tubing on the floor to the left of her bed. Resident R9 stated that she had removed her oxygen because she was waiting for the nurse aide to assist her with bathing. During this observation it was noted that no date was present on the nasal cannula tubing. The humidifier attached to the oxygen concentrator was empty and dated 3/30/34. The filter on the back of the oxygen concentrator was visibly soiled with a layer of gray dust. Resident R9 stated, I believe it, sometimes I can smell dust when I have my oxygen on.</p> <p>During an interview on 4/8/24, at 1:40 p.m. Registered Nurse (RN) Employee E14 confirmed that no date was present on Resident R9's nasal cannula tubing, the humidifier bottle was empty, and that the oxygen concentrator had a visible layer of gray dust present on the filter.</p> <p>Review of the clinical record indicated Resident R13 was admitted to the facility on [DATE].</p> <p>Review of Resident R13's MDS dated [DATE], indicated diagnoses of chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe), stroke (damage to the brain from an interruption of blood supply), and pain.</p> <p>Review of physician's active orders dated 4/11/24, indicated oxygen at 2 liters via nasal cannula every shift.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 4/8/24, at 10:14 a.m. Resident R13 was in bed with oxygen in place via oxygen concentrator. The filter on the back of the oxygen concentrator was visibly soiled with a layer of gray dust.</p> <p>Interview on 4/8/24, at 10:16 a.m. Nursing Assistant (NA) Employee E16 confirmed the filter was dirty.</p> <p>Review of the clinical record indicated Resident R45 was admitted to the facility on [DATE].</p> <p>Review of Resident R45's MDS dated [DATE], indicated diagnoses of Non-Alzheimer's Dementia (condition where memory loss and signs of Parkinson's disease {tremors} present together), left eye blindness, and high blood pressure.</p> <p>Review of physician's active orders dated 4/11/24, failed to include an order for oxygen use.</p> <p>Observation on 4/8/27, at 11:16 a.m. Resident R45's oxygen cannula was lying on the dirty floor; the humidifier was dated 3/27/24.</p> <p>Interview with RN Employee E7 on 4/8/24, at 11:18 a.m. indicated the humidifier was outdated and the oxygen was lying on the floor.</p> <p>Interview with the Director of Nursing on 4/10/24, at 3:00 p.m. confirmed there was not a physician order for Resident R45's oxygen and confirmed the facility failed to provide appropriate respiratory care for three of three residents (Resident R9, R13, and R45).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on review of resident clinical records, facility policy and staff interview it was determined the facility failed to provide consistent and complete communication with the dialysis center for three of four residents reviewed (Resident R5, R8, and R11).</p> <p>Findings include:</p> <p>Review of the facility policy Dialysis Hemodialysis (HD) - Communication and Documentation dated 11/1/23, indicated the center staff will communicate with the dialysis (the clinical purification of blood by dialysis as a substitute for the normal function of the kidney) facility regarding the ongoing assessment of the patient's condition by monitoring for complications before and after hemodialysis treatments received at the dialysis facility.</p> <p>Review of the clinical record indicated that Resident R5 was admitted to the facility on [DATE].</p> <p>Review of Resident R5's Minimum Data Set (MDS - a periodic assessment of care needs), dated 2/3/24, indicated diagnoses of hypertension (high blood pressure), renal failure (one or both kidneys cannot function on their own), and heart failure (heart doesn't pump blood as well as it should). Section O: Special Treatments, Procedures, and Programs, Question O0110 indicated that Resident R5 received dialysis while a resident.</p> <p>Review of R5's current physician orders on 4/12/24, indicated dialysis on Monday, Wednesday, and Friday.</p> <p>Review of Resident R5's care plan dated 2/15/24, indicated the resident will have no signs and symptoms of complications from dialysis.</p> <p>Review of Resident R5's Hemodialysis Communication Forms indicated 25 hemodialysis sheets were present and 24 were incomplete in the dialysis facility's report to the facility and/or the facility's licensed nurse post-hemodialysis monitoring on 2/9/24, 2/12/24, 2/16/24, 2/19/24, 2/21/24, 2/23/24, 2/26/24, 2/28/24, 3/1/24, 3/4/24, 3/6/24, 3/8/24, 3/11/24, 3/13/24, 3/15/24, 3/18/24, 3/20/24, 3/22/24, 3/25/24, 3/27/24, 3/29/24, 4/1/24, 4/3/24, and 4/8/24.</p> <p>During an interview on 4/9/24, at 11:00 a.m. Registered Nurse (RN) Employee E7 indicated the forms listed above were not complete as required.</p> <p>Review of the clinical record indicated that Resident R8 was admitted to the facility on [DATE].</p> <p>Review of Resident R8's Minimum Data Set (MDS - a periodic assessment of care needs), dated 2/16/24, indicated diagnoses of hypertension (high blood pressure), renal failure (one or both kidneys cannot function on their own), and diabetes mellitus (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Section O: Special Treatments, Procedures, and Programs, Question O0110 indicated that Resident R8 received dialysis while a resident.</p> <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R8's current physician orders on 4/12/24, indicated dialysis on Tuesday, Thursday, and Saturday.</p> <p>Review of Resident R8's care plan dated 2/29/24, indicated the resident will have no signs and symptoms of complications from dialysis.</p> <p>Review of Resident R8's Hemodialysis Communication Forms indicated 11 hemodialysis sheets were present and 11 were incomplete in the dialysis facility's report to the facility and/or the facility's licensed nurse post-hemodialysis monitoring on 3/5/24, 3/7/24, 3/9/24, 3/12/24, 3/14/24, 3/16/24, 3/19/24, 3/21/24, 3/23/24, 4/2/24, and 4/9/24.</p> <p>During an interview on 4/12/24, at 11:00 a.m., Unit Manager Registered Nurse (RN) Employee E9 indicated the forms listed above were not complete as required.</p> <p>Review of the clinical record indicated Resident R11 was admitted to the facility on [DATE].</p> <p>Review of Resident R11's MDS dated [DATE], indicated diagnoses of renal failure, orthostatic hypotension (low blood pressure that happens when standing up from sitting or lying down, hemiplegia (paralysis on one side of the body). Section O: Special Treatments, Procedures, and Programs, Question O0110 indicated Resident R11 received dialysis while a resident.</p> <p>Review of a physician's order dated 1/10/24, indicated Resident R11 received dialysis at an outside facility on Monday, Wednesday, and Friday.</p> <p>Review of Resident R11's Hemodialysis Communication Forms indicated 29 hemodialysis sheets were present and 13 were incomplete in the dialysis facility's report to the facility and/or the facility's licensed nurse prior and post-hemodialysis monitoring on 12/14/23, 1/15/24, 1/17/24, 1/22/24, 1/26/24, 2/5/24, 2/23/24, 3/4/24, 3/13/24, 3/18/24, 3/22/24, 3/29/24, and 4/3/24.</p> <p>During an interview on 4/9/24, at 9:23 a.m. the Director of Nursing (DON) confirmed the forms listed above were not complete as required.</p> <p>Interview on 4/12/24, at 2:40 p.m. the DON confirmed the facility failed to provide consistent and complete communication with the dialysis center for three of four residents reviewed (Resident R5, R8, and R11).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing service.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27424</p> <p>Based on review of clinical record review and staff interviews it was determined that the facility failed to provide culturally appropriate, trauma care in accordance with professional standards of practice, accounting the residents past experiences and preferences in order to eliminate and/or mitigate triggers that may cause re-traumatization of the resident for one of two residents (Resident R38) psychiatric services for one of two residents (Resident R38).</p> <p>Findings include:</p> <p>Review of the clinical record revealed that Resident R38 was admitted to the facility on [DATE].</p> <p>Review of the facility diagnosis indicated diabetes, and major depression disorder, which remained current as of the MDS dated [DATE] (a periodic assessment of resident needs).</p> <p>Review of the clinical record care plans indicated the following: At risk for behavior symptoms r/depression, PTSD, anxiety disorder. Last revised 6/11/20.</p> <p>At risk for changes in mood r/depression, PTSD, anxiety disorder. Last revised 6/11/20.</p> <p>Post Trauma Syndromes evidenced by child abuse subsequent mental breakdown at age 12 R/T distressing event outside the range of usual human experience revised 6/8/20.</p> <p>Review of the clinical record failed to include any documentation addressing any of the above PTSD care plans for psychiatric services or social services.</p> <p>During an interview on 4/12/24, at 11:19 a.m. Nursing Home Administrator confirmed that the facility failed to provide culturally appropriate, trauma care in accordance with professional standards of practice, accounting the residents past experiences and preferences in order to eliminate and/or mitigate triggers that may cause re-traumatization of the resident for Resident R38.</p> <p>28 Pa. Code 211.10(a)Resident care polices.</p> <p>28 Pa. Code211.12(d)(3)(5)Nursing services.</p>

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>41984</p> <p>Based on review of personnel records, and staff interview it was determined that the facility failed to complete annual performance evaluations for five out of five nurse aides (NA Employee E2, E3, E4, E5 and E6).</p> <p>Findings include:</p> <p>Review of personnel files revealed that Nurse Aide Employee E2 last hire date was 12/10/22, there was no performance evaluations was completed in file.</p> <p>Review of personnel files revealed that Nurse Aide Employee E3 last hire date was 12/10/22, last performance evaluation was completed 5/2/19-5/1/20.</p> <p>Review of personnel files revealed that Nurse Aide Employee E4 last hire date was 12/10/22, last performance evaluation was completed 5/2/19-5/1/20.</p> <p>Review of personnel files reviewed that Nurse Aide Employee E5 start date was 12/10/22, last performance evaluation was completed 2/8/20-2/7/21.</p> <p>Review of personnel files reviewed that Nurse Aide Employee E6 start date was 12/10/22, last performance evaluation was completed 2/8/20-2/7/21.</p> <p>During an interview on 4/11/24, at 2:20 p.m. Nursing Home Administrator confirmed that the facility does not have up to date performance appraisals completed on NA Employee E2, E3, E4, E5 and E6.</p> <p>28 Pa Code: 201.20 (a)(b)(c)(d) Staff development.</p> <p>28 Pa Code: 201.14 (a) Responsibility of licensee.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>48546</p> <p>Based on review of facility policies, observations, and staff interviews it was determined that the facility failed to accurately label and date open medications for one of four sampled medication carts (MedBridge Med Cart) and one of four sampled medication room (1 South Med Room).</p> <p>Findings include:</p> <p>Review of facility policy Storage and Expiration Dating of Medications, Biologicals dated 11/1/23, indicated once any medication or biological package is opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened. If a multi-dose vial of an injectable medication has been opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. Facility should ensure that food is not to be stored in the refrigerator, freezer, or general storage areas where medications and biologicals are stored.</p> <p>An observation on 4/10/24, at 8:50 a.m. of the MedBridge medication cart revealed the following medication's not dated upon opening:</p> <ul style="list-style-type: none"> - Resident R77's Trelegy inhaler (a medication used to ease breathing) - Resident R110's Lantus pen (prefilled pen to inject long acting insulin under the skin) - Resident R180's Stiolto inhaler (a medication used to ease breathing) - Resident R187's Lantus - Resident R187's Lispro pen (prefilled pen to inject rapid acting insulin under the skin) <p>During an interview on 4/10/24, at 8:53 a.m. Licensed Practical Nurse (LPN) Employee E13 confirmed the findings noted above.</p> <p>During an interview on 4/10/24, at 12:45 p.m. the Director of Nursing (DON) confirmed that the facility failed to accurately label and date open medications for one of four sampled medication carts (MedBridge Med Cart).</p> <p>An observation on 4/8/24, at 1:35 p.m. of the One South Medication Room revealed the following:</p> <p>Tuberculin (medication used to treat diabetes) vial opened, and undated.</p> <p>Trulicity pen, opened and undated.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A can of Red Bull sugar free beverage.</p> <p>During an interview on 4/8/24, at 1:35 p.m. Registered Nurse (RN) Employee E8 confirmed the medications were not dated and that a food/beverage was inappropriately stored in the medication refrigerator.</p> <p>Interview with the Director of Nursing on 4/12/24, at 2:40 p.m. confirmed the facility failed to accurately label and date open medications for one of four sampled medication carts (MedBridge Med Cart) and one of four sampled medication room (1 South Med Room).</p> <p>28 Pa. Code: 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41984</p> <p>Based on observations and staff interview, it was determined that the facility failed to properly label and date food products in the walk in cooler in the designated Main Kitchen and resident refrigerator, failed to maintain sanitary conditions in the Dish Room which created the potential for cross contamination (main kitchen, dish room, first floor refrigerator).</p> <p>Findings include:</p> <p>During an observation of the main designated kitchen on 4/8/24, at 9:25 a.m. the following was observed:</p> <ul style="list-style-type: none"> - 2 bag of coleslaw mix-no label or date - 5 package of American cheese- no date - 8 Grilled cheese- no label or date - 1 bag of coconut- no label or date - 1 container of dinner rolls- no label or date <p>During an observation of the main designated kitchen on 4/8/24, at 9:30 a.m. the following was observed:</p> <ul style="list-style-type: none"> -Industrial size fan brown debris covering surface -Wall beside dirty side of dishwasher, food debris, black like substance covering the wall <p>During an interview on 4/8/24, at 1:05 p.m. Dietary Manager Employee E1 confirmed that the facility failed to properly label and date food products and maintain sanitary conditions which created the potential for food borne illness.</p> <p>During an observation of the first floor resident refrigerator on 4/8/24, at 1:30 p.m. the following was observed:</p> <p>1st Floor refrigerator contained:</p> <ul style="list-style-type: none"> -pizza, dated 3/21/24-no resident name -2 containers of applesauce-no label or date -coleslaw-no label or date -cake-dated 3/2/24 <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 4/8/24, at 2:00 p.m. Nursing Home Administrator confirmed the facility failed to label and date as required.</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p> <p>28 Pa. Code: 211.6(c) Dietary services.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p>

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>41984</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on review of facility policy, Quality Assurance attendance records, and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance and Performance Improvement (QAPI) meetings at least quarterly for one of four quarterly meeting (April 2024 through June 2024).</p> <p>Findings Include:</p> <p>The facility Center Quality Assurance Performance Improvement Process policy dated 11/9/23, indicated the QA Committee consisting of the administrator, Director of Nursing, Medical Director, Infection Preventionist. The committee meets at least quarterly, to review data, suggestions and input from patients, staff, family member and other stakeholders.</p> <p>Review of Quality assurance and performance sign in sheets and attendance records from May 2023 through March 2024 did not include sign in documentation for meetings from April 2024 through June 2024.</p> <p>During an interview on 4/11/24, at 10:10 a.m. the Nursing Home Administrator confirmed that the facility failed to conduct Quality Assessment and Performance Improvement (QAPI) meetings at least quarterly as required.</p> <p>28 Pa Code: 201.18(e)(1)(2)(3)(4) Management</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48546</p> <p>Based on facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to implement an infection control program that included a system of surveillance to identify possible communicable diseases or infections for four of ten months (October 2023, January 2024, February 2024, and March 2024) and failed to properly disinfect reusable equipment between residents for one of four medication carts observed (MedBridge Med Cart).</p> <p>Findings include:</p> <p>Review of facility policy Point of Care Testing (POCT) dated 1/11/23, indicated to disinfect POCT equipment before and after patient use and before storing as instructed by the manufacturer.</p> <p>Review of the EvenCare G2 Blood Glucose Monitoring System manual indicated the following approved products for cleaning and disinfecting the EvenCare G2 Meter:</p> <ul style="list-style-type: none"> - Dispatch Hospital Cleaner Disinfectant Towels with Bleach - Medline Micro-Kill+ Disinfecting, Deodorizing, Cleaning Wipes with Alcohol - Clorox Healthcare Bleach Germicidal and Disinfectant Wipes - Medline Micro-Kill Bleach Germicidal Bleach Wipes <p>Review of the facility's Infection Control documentation for the previous ten months (June 2023 - March 2024), failed to reveal surveillance for tracking infections for residents for four of ten months (October 2023, January 2024, February 2024, and March 2024).</p> <p>During an observation on 4/8/24, at 8:47 a.m. Licensed Practical Nurse (LPN) Employee E13 was observed cleaning the shared glucometer machine (equipment used to monitor blood sugars) with an alcohol prep pad (gauze swab impregnated with alcohol solution) after obtaining a blood sample from a resident.</p> <p>During an interview on 4/8/24, at 8:48 a.m. LPN Employee E13 confirmed that she did not clean the glucometer machine with the approved disinfectant per facility policy and manufacturer guidelines. LPN Employee E13 stated, The facility told me to use an alcohol swab to clean the glucometer before and after each resident.</p> <p>During an interview on 4/10/24, at 12:45 p.m. the Director of Nursing confirmed that the facility failed to implement an infection control program that included a system of surveillance to identify possible communicable diseases or infections for four of ten months (October 2023, January 2024, February 2024, and March 2024) and failed to properly disinfect reusable equipment between residents for one of four medication carts observed (MedBridge Med Cart).</p> <p>28 Pa. code: 201.14(a) Responsibility of licensee.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024
NAME OF PROVIDER OR SUPPLIER Pittsburgh Skilled Nursing and Rehabilitation Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 550 South Negley Avenue Pittsburgh, PA 15232	

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

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code: 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code: 211.10(d) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024
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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>48546</p> <p>Based on review of the facility's infection control policies and procedures and staff interview, it was determined that the facility failed to implement an antibiotic stewardship program for four of ten months (October 2023, January 2024, February 2024, and March 2024).</p> <p>Findings include:</p> <p>Review of facility policy Antibiotic Stewardship dated 11/1/23, indicated centers will implement an Antibiotic Stewardship Program that includes antibiotic use protocols and systems for monitoring antibiotic use.</p> <p>Review of the facility's Infection Control surveillance for June 2023, through March 2024, failed to include documentation to indicate that antibiotic monitoring was completed for October 2023, January 2024, February 2024, and March 2024.</p> <p>During an interview on 4/10/24, at 12:45 p.m. the Director of Nursing confirmed that the facility failed to implement an antibiotic stewardship program for four of ten months (October 2023, January 2024, February 2024, and March 2024.)</p> <p>28 Pa. Code: 211.10(c)(d) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024
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<p>F 0920</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture.</p> <p>27424</p> <p>Based on observations and staff interviews it was determined that the facility failed to provide dining areas for two nursing units out of four nursing units (3rd floor secured unit and 3rd floor pavilion).</p> <p>Findings include:</p> <p>During observations on 4/10/24, from 7:31 a.m. to 8:35 a.m. on the 3rd floor nursing unit - no dining room was available for residents to eat their breakfast. Activity room is locked and residents have access when activity staff are available (not in building breakfast or dinner for most days).</p> <p>During observation on 4/10/24, at 1:49 p.m. in the 3rd floor secured unit no seating was noted in the dining room with few tables.</p> <p>During an interview on 4/12/24, at 11:13 a.m. NHA (Nursing Home Administrator) confirmed that the 3rd floor pavilion did not have a dining area, and the 3rd floor secured unit did not have adequate furniture in the dining g area for the resident to eat their meals.</p> <p>28 Pa. Code 205.24 Dining room</p>