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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395251	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy Park Post Acute	5609 Fifth 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)
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** 48546 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to ensure that a resident was free from neglect by not providing a two-person bed mobility assistance for one of four residents (Resident R1) resulting in a fall. Findings include: Review of facility policy Abuse Prohibition dated 9/30/24, indicated neglect is defined as the failure, indifference, or disregard of the Center, its employees, or service providers to provide care, comfort, safety, goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This includes the failure to implement an effective communication system across all shifts for communicating necessary care and information between Center, patient, practitioners, and patient representatives. Review of facility policy Activities of Daily Living (ADLs) dated 9/30/24, indicated ADLs include bathing, dressing, grooming, transfer and ambulation, toileting, dining, and communication. A patient who is unable to carry out ADLs will receive the necessary level of ADL assistance to maintain good nutrition, grooming, and personal and oral hygiene. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/24/24, indicated diagnoses of high blood pressure, quadriplegia (paralysis of all four limbs), and Multiple Sclerosis (a disease that affects central nervous system). Section GG - Functional Abilities, Question GG0170 Mobility indicated Resident R1 was coded as 1 dependent with the helper doing all of the effort or the assistance of two or more helpers is required to complete roll left and right bed mobility. Review of Resident R1's care plan dated 7/10/23, indicated the resident required an assist of two to complete bed mobility. Review of Resident R1's Kardex (a snapshot of resident care needs) dated 10/4/24, indicated the resident required an assist of two for ADLs. (continued on next page)

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note dated 10/4/24, completed by Licensed Practical Nurse (LPN) Employee E3 stated, Nurse Aide (NA) staff came out to let this nurse know that resident had accidentally rolled onto floor while she was changing hi. Registered Nurse (RN) Supervisor was called down to the unit right away to assess. Review of a progress note dated 10/4/24, completed by RN Employee E5 stated, Notified by nurse on cart that resident is on the floor. Upon entering the room observed resident laying on his back by the right side of his bed. Head to toe assessment performed on resident no physical injuries noted. Resident stated he had a spasm and it threw him on the floor. Denies pain at this time. Resident was assisted back to bed with a hoyer lift (a mechanical lift). Nurse on cart will follow up with fall protocol. Review of a verbal statement dated 10/7/24, obtained by RN Employee E4 indicated NA Employee E1 stated, I was providing incontinence care alone to Resident R1. I was in the middle of washing him up, I turned him on his side. During the time when he was on his side, I realized that I needed new briefs for him. I left the room to obtain the briefs. On my way back to the room, I heard the resident yell out I am going to fall! The resident also yelled out I am having spasms! I then heard a loud crash and entered the room to see the resident on the floor. He had fallen out of the bed. During an interview on 11/6/24, at 12:13 p.m. the Nursing Home Administrator (NHA) confirmed that Resident R1 was ordered an assist of two people to complete bed mobility and two people should have been in the room while Resident R1 was receiving care and fell out of bed on 10/4/24. During an interview on 11/6/24, at 12:13 p.m. the NHA confirmed that the facility failed to ensure that a resident was free from neglect by not providing a two-person bed mobility assistance as required for one of four residents (Resident R1) resulting in a fall. 28. Pa Code 201.14(a) Responsibility of licensee. 28. Pa Code 201.18(b)(1)(e)(1) Management. 28. Pa. Code 211.12(d)(1)(5) Nursing services.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to provide adequate supervision for bed mobility needs, resulting in an avoidable fall for one of four residents (Resident R1). Findings include: Review of facility policy Accidents/Incidents dated 9/30/24, indicated an accident is defined as any unexpected or unintentional incident which may result in injury or illness to a patient. Review of facility policy Activities of Daily Living (ADLs) dated 9/30/24, indicated ADLs include bathing, dressing, grooming, transfer and ambulation, toileting, dining, and communication. A patient who is unable to carry out ADLs will receive the necessary level of ADL assistance to maintain good nutrition, grooming, and personal and oral hygiene. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/24/24, indicated diagnoses of high blood pressure, quadriplegia (paralysis of all four limbs), and Multiple Sclerosis (a disease that affects central nervous system). Section GG - Functional Abilities, Question GG0170 Mobility indicated Resident R1 was coded as 1 dependent with the helper doing all of the effort or the assistance of two or more helpers is required to complete roll left and right bed mobility. Review of Resident R1's care plan dated 7/10/23, indicated the resident required an assist of two to complete bed mobility. Review of Resident R1's Kardex (a snapshot of resident care needs) dated 10/4/24, indicated the resident required an assist of two for ADLs. Review of a progress note dated 10/4/24, completed by Licensed Practical Nurse (LPN) Employee E3 stated, Nurse Aide (NA) staff came out to let this nurse know that resident had accidentally rolled onto floor while she was changing hi. Registered Nurse (RN) Supervisor was called down to the unit right away to assess. Review of a progress note dated 10/4/24, completed by RN Employee E5 stated, Notified by nurse on cart that resident is on the floor. Upon entering the room observed resident laying on his back by the right side of his bed. Head to toe assessment performed on resident no physical injuries noted. Resident stated he had a spasm and it threw him on the floor. Denies pain at this time. Resident was assisted back to bed with a hoyer lift (a mechanical lift). Nurse on cart will follow up with fall protocol. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a verbal statement dated 10/7/24, obtained by RN Employee E4 indicated NA Employee E1 stated, I was providing incontinence care alone to Resident R1. I was in the middle of washing him up, I turned him on his side. During the time when he was on his side, I realized that I needed new briefs for him. I left the room to obtain the briefs. On my way back to the room, I heard the resident yell out I am going to fall! The resident also yelled out I am having spasms! I then heard a loud crash and entered the room to see the resident on the floor. He had fallen out of the bed. During an interview on 11/6/24, at 12:13 p.m. the Nursing Home Administrator (NHA) confirmed that Resident R1 was ordered an assist of two people to complete bed mobility and two people should have been in the room while Resident R1 was receiving care and fell out of bed on 10/4/24. During an interview on 11/6/24, at 12:13 p.m. the NHA confirmed that the facility failed to provide adequate supervision for bed mobility needs, resulting in an avoidable fall for one of four residents (Resident R1). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(e)(1) Management. 28 Pa. Code: 207.2(a) Administrator's responsibility. 28 Pa. Code: 211.10(d) Resident care policies.

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F 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or arrange emergency care by a doctor 24 hours a day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to ensure the provision of consistent and timely physician services for one of four residents (Resident R1). Findings include: Review of facility policy Physician/Advanced Practice Practitioner (APP) Notification dated 9/30/24, indicated upon identification of a patient who has a change in condition, abnormal laboratory values, or abnormal diagnostics, a licensed nurse will report to physician/APP. If unable to contact attending physician/APP, the Medical Director will be contacted. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/24/24, indicated diagnoses of high blood pressure, quadriplegia (paralysis of all four limbs), and Multiple Sclerosis (a disease that affects central nervous system). Review of a Resident Representative Concern dated 10/25/24, stated, On Tuesday 10/8 he stated he didn't feel well and needed to go to the ER (emergency room). All the aides and nurses ignored his request for emergency care. On 10/9 I got a call from him and he stated he was feeling awful and needed the ER. I called and spoke to a nurse who stated he wasn't sent the night before because they never heard back from the doctor. I demanded he be sent. The hospital told me his urine was backed up into his kidneys, his BP (blood pressure) was low and his stomach was distended and he went into the ICU (Intensive Care Unit) for 4 days. They delayed emergency treatment for him. Review of a Change In Condition note dated 10/9/24, at 12:49 a.m. completed by Registered Nurse (RN) Employee E2 stated, The Change In Condition (CIC) reported on this CIC Evaluation are/were: functional decline (worsening function and/or mobility) Tired, Weak, Confused, or Drowsy. Nursing observations, evaluation, and recommendations are: Resident in no apparent distress. Complaint of Multiple Sclerosis (MS) flare up states he can't describe the feeling, denies pain. States it's a feeling I get when I need an infusion describes feelings as weakness and mobility impairment less than the normal. Resident is calm and relaxed. Insist on going to ER tonight. Resident insisting on ER visit at this time, MD (physician) notified. Review of a Medical Practitioner Note dated 10/9/24, at 1:09 p.m. completed by Physician Assistant Employee E6 stated, Per nursing, patient has been feeling unwell and requesting to be sent to the hospital. Patient with a history of recurrent MS flares requiring intravenous corticosteroids. Patient is found resting comfortably in bed, reports that he feels very bad. He is weak and tired and has pain from his shoulder all the way down his body. He refuses oral prednisone (a steroid given to suppress inflammation and the normal immune response) treatment here when I discuss alternative treatments instead of going to the hospital. He would really like to go to the hospital because he knows they can get him back to feeling better in a few days. Send to emergency room for evaluation and treatment. (continued on next page)

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F 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note dated 10/9/24, completed by RN Employee E3 stated, 10:45 p.m. emergency room called to check on resident's status, admitted to the Medical ICU with sepsis (the body's extreme response to an infection that can be life threatening). During a telephonic interview on 11/6/24, at 12:29 p.m. RN Employee E2 stated, Resident R1 told me he wasn't feeling good, he said he had a MS flare up. I called the doctor and he didn't answer the phone so I texted him, this was around 1 a.m. on 10/9/24. The doctor texted me back around 6 a.m. on 10/9/24. I told Resident R1 that I would tell the practitioners know in the morning to check on him. During an interview on 11/6/24, at 1:08 p.m. the Nursing Home Administrator (NHA) stated, I'm not sure what the procedure was at that time if staff couldn't get ahold of the physician at night. We have a procedure in place now when a physician does not respond. That physician is usually great about responding. During an interview on 11/6/24, at 1:08 p.m. the NHA confirmed that the facility failed to ensure the provision of consistent and timely physician services as required for one of four residents (Resident R1). 28 Pa. Code 211.2 (a)(d)(2) Physician services.