

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395251	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Ivy Park Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</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 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** Based on observations, facility policy, and staff interview, it was determined that the facility failed to provide a clean, safe, comfortable, and homelike environment for one of three floors (3rd floor) and failed to ensure comfortable air temperature levels were provided for one of three floors (4th floor). Findings Include: Review of the facility policy Safe and Homelike Environment dated 5/20/25, indicated residents are provided a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect personalized, homelike setting. These characteristics include: Clean, sanitary and orderly environment; Comfortable and safe temperatures (71 degrees Fahrenheit - 81 degrees Fahrenheit). During an observation conducted on 1/8/26, from 10:35 a.m. to 10:50 a.m., with the Director of Nursing (DON) revealed the following: 3rd floor low hallway shower room/stall - had a build-up of red grime, and black debris located where the wall meets the floor. 3rd floor high hallway shower room/stall - had a build-up of red grime, and black debris located where the wall meets the floor. During an interview on 1/8/26, at 11:02 a.m., the DON confirmed the 3rd floor shower areas (low and high hall) failed to be clean and sanitary. Review of facility provided Air Temperature log, dated 1/8/25, from 11:00 a.m. to 11:45 a.m., conducted while onsite by Director of Maintenance (DOM) Employee E1, revealed the following air temperatures: 4th floor Nursing unit: room [ROOM NUMBER] - 83.0 degrees Fahrenheit room [ROOM NUMBER] - 84.0 degrees Fahrenheit room [ROOM NUMBER] - 86.0 degrees Fahrenheit room [ROOM NUMBER] - 86.0 degrees Fahrenheit room [ROOM NUMBER] - 86.0 degrees Fahrenheit room [ROOM NUMBER] - 86.0 degrees Fahrenheit room [ROOM NUMBER] - 85.0 degrees Fahrenheit room [ROOM NUMBER] - 86.0 degrees Fahrenheit room [ROOM NUMBER] - 87.0 degrees Fahrenheit room [ROOM NUMBER] - 87.0 degrees Fahrenheit Dining room area - 88.0 degrees Fahrenheit During an interview on 1/8/26, at 12:04 p.m., the DOM Employee E1 confirmed the facility failed to ensure comfortable air temperature levels were provided for the 4th floor (11 resident rooms and dining room area). During an interview on 1/9/26, at 3:00 p.m., the Nursing Home Administrator (NHA) confirmed that the facility failed to provide a clean, safe, comfortable, and homelike environment for one of three floors (3rd floor) and failed to ensure comfortable air temperature levels were provided for one of three floors (4th floor) as required. 28 Pa. Code: 201.18(b)(3) Management</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 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the American Heart Association (AHA) Guidelines, clinical records, facility policies, and staff interviews it was determined that the facility failed to ensure consistent care by initiating Cardiopulmonary Resuscitation (CPR) to an unresponsive resident for one of 73 residents (Closed Record Resident CR1), resulting in immediate jeopardy. Findings include: The Pennsylvania Code Title 49, Professional and Vocational Standards through the Department of State indicates under Responsibilities of the Registered Nurse 21.11 General functions (a) The registered nurse assesses human responses and plans, implements, and evaluates nursing care for individuals or families for whom the nurse is responsible. In carrying out this responsibility, the nurse performs all the following functions: (4) Carries out nursing care actions which promote, maintain, and restore the well-being of individuals. Review of AHA Guidelines indicated: - if a person is unresponsive with no breathing and has no pulse for more than 10 seconds, start CPR. According to American Heart Association guidelines presumptive Signs of Death are as follows: The patient is unresponsive. The patient has no respirations. The patient has no pulse. The patient's pupils are fixed and dilated. The patient's body temperature indicates hypothermia: skin is cold relative to the patient's baseline skin temperature. The patient has generalized cyanosis (bluish skin color due to decreased amounts of oxygen). AHA guidelines for Conclusive (irreversible) Signs of Death are as follows: There is presence of lividity (venous pooling of blood in dependent body parts causing purple discoloration of the skin, due to the cessation of circulation). While these signs of irreversible death would not be expected to be seen in most practice settings, the American Heart Association also includes the following irreversible signs of death: decapitation (separation of the head from the body). decomposition (decay or putrefaction of the body); and rigor mortis (stiffness of the limbs and body that develops 2 - 4 hours after death and may take up to 12 hours to fully develop). Review of facility policy Emergency Procedure - Cardiopulmonary Resuscitation, dated [DATE], indicated personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support (BLS), including defibrillation, for victims of sudden cardiac arrest. General guidelines: Sudden cardiac arrest (SCA) is a loss of heart function due to abnormal heart rhythms (arrhythmias). Cardiac arrest occurs soon after symptoms appear. It is a leading cause of death among adults. A heart attack refers to impaired blood flow to the heart which leads to damage of the heart muscle. A heart attack can cause sudden cardiac arrest. Typically heart attacks are less sudden than SCA. Victims of cardiac arrest may initially have gasping respirations or may appear to be having a seizure. Training in BLS includes recognizing presentations of SCA. The chances of surviving SCA may be increased if CPR is initiated immediately upon collapse. Early delivery of shock with defibrillator plus CPR within 3-5 minutes of collapse can further increase chances of survival. In an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless: It is known that a do not resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual; or There are obvious signs of irreversible death (e.g. rigor mortis) If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR or a physician's order not to administer CPR. Review of Resident CR1's clinical record indicated an admission date of [DATE]. Review of Resident CR1's Minimum Data Set (MDS-a periodic assessment of care needs) dated [DATE], indicated diagnoses of chronic kidney disease (long-term condition where the kidneys gradually lose their function over time), adult failure to thrive (condition where an older adult loses appetite, weight, and</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>interest in activities), and high blood pressure. Review of Resident CR1's physician order dated [DATE], current through [DATE], indicated the resident was a full code (allows for all interventions needed to restore breathing or heart functioning). Resident CR1 ceased to breathe on [DATE], at 7:56 a.m. Review of Resident CR1's clinical record form Advance Directives dated [DATE], indicated resident had no advance directives, no living will, and no Power of Attorney. Review further noted that additional information was requested and on [DATE], PA Advance Directive Packet was provided by Social Service Employee E2 to Resident CR1. Review of Resident CR1's care plan initiated [DATE], current through [DATE], failed to identify goals, plans, and/or interventions related to resident's full code status. Review of Resident CR1's clinical progress note dated [DATE], at 7:50 a.m., entered by Licensed Practice Nurse (LPN) Employee E3, indicated that at 7:45 a.m., resident (CR1) was lying in bed on her right side. (CR1) did not respond to name being called. Eyes were open. Skin was pale and cool. Call bell was within reach. Registered Nurse (RN) Supervisor notified. Medical Doctor (MD) notified for change in condition. Further review of Resident CR1's clinical progress note dated [DATE], late entry at 10:13 a.m., entered by RN Employee E4, indicated this nurse (E4) was notified that resident (CR1) CTB (cease-to-breathe) this morning at 7:56 a.m., MD was notified. Resident has no emergency contact. Funeral home was contacted for resident to be released; awaiting return call. Care has been completed on resident. Review of facility provided employee statement by LPN Employee E3, on [DATE], stated that this nurse (E3) rounded on patient (CR1) at 7:45 a.m. Patient (CR1) was lying in bed on her right side. Patient (CR1) did not respond to name being called. Eyes were open. Skin was pale and cool. CPR was not started due to irreversible death. RN supervisor notified. Physician notified of change in condition. Review of facility provided employee statement by RN Employee E4, on [DATE], stated (E4) was informed by oncoming nurse of resident's (CR1) change in condition. The MD was contacted and we were waiting for a return phone call to verify next steps. (RN E4) checked on resident when (E4) was notified of change, (CR1) was resting in bed at that time. (LPN E3) alerted (E4) about an hour later that (CR1) was checked on again and had no pulse. At that time, (LPN E4) stated (CR1)'s eyes were open, (CR1) was pale and cool. Upon assessment, aside from the obvious signs of death (no pulse, apical HR (heart rate), and respirations) it was determined that due to (LPN E4)'s assessment as well as mottling (common sign that occurs as a person approaches death, characterized by a marbled or blotchy appearance of the skin, typically indicating reduced blood circulation) in extremities, that the resident (CR1) had signs of irreversible death and CPR would not have helped. MD was contacted and resident (CR1) was pronounced CTB at 7:56 a.m. During an interview on [DATE], at 11:20 a.m., LPN Employee E5 stated that if they walk into a room and a resident is pulseless, that they would call the RN supervisor, determine resident's code status in medical record, and if full code, initiate CPR. During an interview on [DATE], at 11:28 a.m., LPN Employee E6 stated that if a resident is found without respirations or a pulse, that a code would be called, alerting RN supervisor to room, then check code status and initiate CPR for full code status. During an interview on [DATE], at 11:35 a.m., LPN Employee E7 stated that if a resident is found pulseless, a code would be called, crash cart grabbed, and code status confirmed prior to initiating CPR. During an interview on [DATE], at 11:40 a.m., LPN Employee E8 stated once a resident is confirmed pulseless, check code status, and initiate CPR. During an interview on [DATE], at 11:45 a.m., RN Employee E9 stated that code status is checked when a resident if found pulseless, and CPR is initiated if full code. Employee E9 further stated that by the time the RN responds to a code, LPN's have initiated CPR, RN supports and supervises, calls 911, and directs paramedics on arrival. During an interview on [DATE], at 11:55 a.m., RN Employee E10 stated that CPR is initiated after checking medical chart for DNR or Full Code,</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>call code, and then react; AED (automated external defibrillator) and crash cart are on every unit. Review of Resident CR1's clinical record failed to indicate that CPR was administered as ordered. This failure to provide CPR resulted in an immediate jeopardy situation, placing all residents at risk if they become unresponsive or pulseless. On [DATE], at 3:06 p.m., the Nursing Home Administrator (NHA) and the Director of Nursing (DON) were notified that an immediate jeopardy was identified and were provided a copy of the completed IJ template. On [DATE], at 5:15 p.m., an Immediate Action Plan was accepted with the following actions: Immediate Action: Resident R1 no longer resides in facility. All professional nursing staff (LPN/RN) will be re-educated by end-of-day (EOD) [DATE], on the CPR procedure. Agency staff will be educated prior to the start of their next shift. All professional nursing staff (LPN/RN) will be re-educated by EOD [DATE], on the definition of irreversible death and that it must be documented in the clinical record. Agency staff will be educated prior to the start of their next shift. Whole-house audit will be conducted by the DON/designee to ensure that every resident has a completed POLST (Physician Order for Life Sustaining Treatment - portable medical order form that tells all health care providers during a medical emergency what you want) order form, the code status order in EHR (electronic health record), and the care plan updated accordingly. Policies related to CPR have been reviewed by NHA and DON and updated to include signs of irreversible death. Facility will review the incident in QAPI (Quality Assurance/Process Improvement) meeting [DATE]. New admissions will be audited by DON/designee weekly times four weeks, then monthly times two months to ensure that the POLST is located in the resident chart and the DNR or Full Code status is in EHR. Findings of audits will be submitted through facility QAPI program. All new hires will be educated on CPR procedures and signs of irreversible death. On [DATE], at 9:06 a.m., it was verified that the facility's policy related to CPR was revised and updated on [DATE]. On [DATE], at 9:54 a.m., it was verified that 42 of 43 licensed nursing staff members (LPN/RN) received education and completed post-test competency prior to the start of their shift via signature sheet. Seven out of seven licensed nursing staff members (LPN/RN) on [DATE], were interviewed and confirmed training and understanding of CPR procedure. On [DATE], at 10:30 a.m., it was verified that whole-house audit was completed to ensure that every resident has a completed POLST order form, the code status order in EHR, and the care plan were updated accordingly. An Ad Hoc QAPI meeting was conducted on [DATE], at 1:30 p.m., and verified via signature sheet. The Director of Nursing (DON) or designee will conduct audits to ensure POLST is located in the resident chart, that the DNR or Full Code status in the EHR and findings will be reported in upcoming QAPI meetings. Audit tool by facility was verified for use moving forward on [DATE]. On [DATE], it was verified that all newly hired licensed staff members (LPN/RN) will be provided education and training on CPR procedures and signs of irreversible death. On [DATE], the Immediate Jeopardy was lifted at 11:20 a.m., after ensuring the Immediate Plan of Correction had been implemented. During an interview on [DATE], at 3:00 p.m., the NHA and DON confirmed that the facility failed to ensure consistent care was provided by initiating Cardiopulmonary Resuscitation (CPR) to an unresponsive resident for one of 73 residents (Closed Record Resident CR1). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 201.29(d)(j) Resident rights. 28 Pa. Code 211.10(c) Resident care policies.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of job descriptions, clinical records and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility to ensure consistent care was provided to initiate Cardio Pulmonary Resuscitation (CPR) to an unresponsive resident, which created an immediate jeopardy situation for one (Resident R1) of 131 residents. Findings include: The job description for the Nursing Home Administrator (NHA) dated 2/2024, stated the primary purpose is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times. The job description for the Director of Nursing (DON) dated 2/2024, stated the DON is a registered nurse who oversees and supervises the care of all the residents. The DON also provides direct resident/patient care. Based on findings identified in this report, the facility failed to ensure consistent care was provided to initiate CPR to an unresponsive resident (Resident R1), which placed the residents in Immediate Jeopardy. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on [DATE], at 3:06 p.m., the NHA and DON were notified that they failed to effectively manage the facility to ensure consistent care was provided to initiate CPR to an unresponsive resident (Resident R1), which created an immediate jeopardy situation for one of 131 residents. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.</p>		