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	06/27/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to ensure that care was provided in a manner which maintained resident dignity for one of four residents (Residents R120). Findings include: Review of facility policy Dignity dated 5/20/25, indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Review of Resident R120's clinical record indicated resident was admitted to the facility on [DATE]. Review of Resident R120's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 5/8/25, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Section M1200 Skin and Ulcer/Injury Treatments indicated pressure ulcer/injury care. Review of Residents R120's physician orders dated 5/21/25, indicated to cleanse right heel with wound cleanser and pat dry. Thera honey (a honey dressing used to treat wounds) to be applied to wound and place silver alginate (a medicated cream) over area and wrap with kling (a type of bandage used to secure dressing) every other day or as needed. Review of the facility provided pressure ulcer list indicated Resident R120 was admitted with a pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) to her right heel on 12/18/24. During an observation of wound care on 6/25/25, from 2:05 p.m. through 2:40 p.m. Registered Nurse (RN) Employee E1 wrote on the dressing after it was placed on Resident R120's right heel. During an interview on 6/25/25, at 2:45 p.m. RN Employee E1 confirmed the facility failed to maintain Resident R120's dignity when writing on the dressings after placement on the resident. 28 Pa. Code: 201.29(j) Resident rights.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on a review of facility documents, observations, and staff interviews, it was determined that the facility failed to maintain a homelike environment for seven of eight residents (Resident R12, R38, R40, R41, R46, R81, and R120). Findings include: A review of facility policy Linen Management dated 5/20/25, indicated to ensure a consistent, sanitary, and efficient process for handling, distribution, and storage of linens used throughout the facility to support resident care. A review of facility policy Homelike Environment dated 5/20/25, indicated residents are provided with a safe, clean, comfortable, and homelike environment. During a tour of the unit on 6/24/25, at 1:00 p.m. the following were observed: - Resident R12's bed had stains on the fitted sheet and pillow case - Resident R38's bed had holes in the fitted sheets - Resident R40's bed had a thin, stretched, see through fitted sheet - Resident R41's bed had holes in the fitted sheets - Resident R46's bed had a dirty, stained blanket - Resident R81's bed had stains on the fitted sheet - Resident R120's bed had a thin, stretched, see through fitted sheet During an interview on 6/24/25, at 1:17 p.m. Licensed Practical Nurse (LPN) Employee E2 confirmed the above findings. During an interview on 6/24/25, at 2:30 p.m. Nursing Home Administrator confirmed that the facility failed to maintain a homelike environment on seven of eight residents. 28 Pa. Code: 201.18(b)(3) Management

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of six residents sampled with facility-initiated transfers (Residents R2, R13) and failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for one of six resident hospital transfers (Resident R13), and failed to obtain a physician order for discharge for one of three residents (Closed Record Residents R127). Findings include: Review of facility policy Transfer or Discharge last reviewed 5/20/25, indicated transfer and discharges must meet specific criteria and require resident/representative notification, orientation, and documentation in the medical record. Review of the clinical record indicated Resident R13 was admitted to the facility on [DATE]. Review of Resident 13's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/27/25, indicated diagnoses of dementia(group of brain disorders that cause a progressive decline in cognitive functions, such as memory, thinking, reasoning, and problem-solving), major depressive disorder(mental health condition characterized by persistent feelings of sadness, loss of interest, and changes in mood and behavior that significantly impact daily life) and urinary tract infection. Review of the clinical record indicated Resident R13 was transferred to the hospital on 4/11/25, and returned to the facility on 4/16/25. Review of Resident R13's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected return, which included the resident's care plan goals and all information necessary to meet the resident's specific needs at the receiving facility, the clinical record also failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 4/11/25. Review of the admission record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS dated [DATE], indicated diagnoses of high blood pressure, anemia (too little iron in the blood), and renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids). Review of the clinical record indicated Resident R2 was transferred to the hospital on 4/28/25. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R2's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected return, which included the resident's care plan goals and all information necessary to meet the resident's specific needs at the receiving facility. Interview with the Director of Nursing on 6/24/25, at 12:43 p.m. confirmed Resident R2 and Resident R13's clinical record did not contain all of the required information prior to transferring to the hospital. Interview with the Director of Nursing on 6/27/25, at 12:15 p.m. confirmed the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for four of six residents sampled with facility-initiated transfers (Residents R2 and R13). During an interview on 6/25/25, at 2:15 p.m. Director of Nursing confirmed that the facility failed to notify the resident or resident's representative of the facility bed-hold policy for of six resident hospital transfers (Residents R13). Review of the clinical record on 6/25/25, indicated Closed Record (CR) Resident R127 was admitted to the faciltiy on 4/24/25, and was discharged home on 5/29/25. Review of the clinical record revealed that CR Resident R127 failed to have a physician discharge order in the clinical record. During an interview on 6/25/25, at 1:27 p.m. Assistant Director of Nursing Employee E1 confirmed that the facility failed to obtain a physician order for discharge for one of three residents (CR Resident R127) 28 Pa. Code: 201.29 (a)(c)(3)(2) Resident rights.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies and clinical records, observations and staff interviews, it was determined that the facility failed to develop comprehensive care plans that included specific and individualized interventions and/or goals to address the care needs of residents for three of five residents reviewed (Resident R4, R25, and R120). Findings include: Review of the facility policy Care Plans Comprehensive Person-centered last reviewed 5/20/25, indicated that a comprehensive, person-centered care plan that includes measurable objectives and time frames, to meet a resident's, physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including but not inclusive to: Services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights, including but not inclusive to: - The right to refuse treatment. - Which professional services are responsible for each element of care. - Includes the resident's stated goals upon admission and desired outcome. - Builds on the resident's strength. - Reflects currently recognized standards of practice for problem areas and conditions. - Services provided for or arranged by the facility and outlined in the comprehensive care plan are: provided by qualified persons, culturally competent and trauma informed. Review of the clinical record revealed that Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/28/25, indicated the diagnoses of coronary artery disease (reduced blood flow to the heart), hypertension (high blood pressure) and acute osteomyelitis (infection in the bone) right foot and ankle. During an observation completed on 06/23/25, at 10:07 a.m. Resident R4 was in bed a wound vac (a vacuum-assisted device that uses negative pressure to pull a wound together) was on her right foot. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R4's physician orders dated 5/27/25, indicated wound vac to be applied Monday, Wednesday and Friday to right distal amputation site. Site to be cleansed with wound cleanser and pat dry after removal. Wound vac to be changed as needed every day shift and as needed. Review of Resident R4's current care plan dated 5/27/25, indicated resident has right foot infection related to right foot amputation and failed to reflect that Resident R4 had a wound vac. During an interview completed on 6/26/25, at 8:28 a.m. the Director of Nursing confirmed the comprehensive care plan did not include interventions for Resident R4's wound vac. Review of the clinical record revealed that Resident R25 was admitted to the facility on [DATE]. Review of Resident R25's MDS dated [DATE], indicated the diagnosis of anemia (low iron in the blood), diabetes (high sugar in the blood) and right leg above the knee amputation. During an observation completed on 6/23/25, at 9:58 a.m. Resident R25 was in his bed a trapeze bar (mobility aid) was noted above his head. Review of Resident R25's current care plan on 6/26/25, failed to include interventions for the over the bed trapeze. During an interview completed 6/26/25, at 12:52 p.m. Licensed Practical Nurse (LPN) Employee E12 confirmed the trapeze above residents bed and stated he uses it to get in and out and confirmed the care plan did not include interventions for the over the bed trapeze. Review of Resident R120's clinical record indicated resident was admitted to the facility on [DATE]. Review of Resident R120's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Residents R120's physician orders dated 1/5/25, indicated resident to wear wander guard/wander elopement device (a device that alarms) due to poor safety awareness, check placement every shift. Review of Resident R120's current care plan on 6/26/25, at 1:04 p.m. failed to include a care plan with interventions, and goals for Wanderguard or elopement. During an interview on 6/26/25, at 1:43 p.m. Registered Nurse Employee E1 confirmed that Resident R120's wanderguard/elopement risk was not care planned. During an interview on 6/25/25, at 2:35 p.m. Director of Nursing confirmed that the facility failed to develop comprehensive care plans that included specific and individualized interventions and/or goals to address the care needs of residents for three of five residents reviewed (Resident R4, R25, and R120). 28 Pa. Code: 211.10(d) Resident care policies. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code: 211.12 (d)(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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, 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 one of four residents (Resident R5). Findings include: The facility policy Activities of Daily Living (ADLs) dated 5/20/25, indicated a patient who is unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Review of admission record indicated Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/14/25, indicated the diagnoses of high blood pressure, heart failure (heart doesn't pump blood as well as it should), and coronary artery disease (damage or disease in the heart's major blood vessels). Section GG0130 Functional Abilities indicated resident was dependent for personal hygiene needs. Observation on 6/23/25, at 9:20 a.m. Resident R5 was resting in bed with a large amount of facial hair to the upper lip and chin. Bilateral hands had black debris underneath the fingernails. Observation on 6/24/25, at 8:45 a.m. Resident R5 was resting in bed with a large amount of facial hair to the upper lip and chin. Bilateral hands had black debris underneath the fingernails. Observation and interview on 6/24/25, at 8:47 a.m. Nurse Aide (NA) Employee E14 confirmed the facial hair and fingernails with debris, and stated I'll let that aide know. Observation on 6/25/25, at 8:37 a.m. Resident R5 was resting in bed with a large amount of facial hair to the upper lip and chin. Bilateral hands had black debris underneath the fingernails. Observation and interview on 6/25/25, at 8:39 a.m. the Assistant Director of Nursing (ADON) Employee E1 confirmed Resident R5 was resting in bed with a large amount of facial hair to the upper lip, chin, and bilateral hands had black debris underneath the fingernails. Interview with the Director of Nursing on 6/27/25, at 12:15 p.m. confirmed the facility failed to provide Activity of Daily Living (ADL) assistance for one of four residents (Resident R5). 28 Pa. Code 211.10(c)(d) Resident Care Policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing Services 28 Pa. Code: 201.18(b)(1) Management.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on review of facility policy, observation, and staff interviews, it was determined that the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for one of three floors (Fourth floor). Findings include: Review of facility policy Activity Programs dated 5/20/25, indicated our activity program are staffed with personnel who have appropriate training and experience to meet the needs and interests of each resident. During a review of activity calendar on 6/25/25, at 10:30 a.m. the following activities were scheduled on the Fourth Floor: - 11:00 a.m. Moovin and Groovin - 2:30 p.m. Connect Four During an observation on 6/25/25, at 11:08 a.m. the Fourth-floor common room had nine residents in the room. Activity aide Employee E21 was sitting at a table with music playing. At 11 :14 a.m. Activity aide Employee E21 was sitting with her head resting on her hand, eating a lollipop and failed to interact with the group of residents at the activity. During an interview on 6/25/25, at 11:20 a.m. Activity aide Employee E21 stated that the activity was Moovin and Groovin. When asked to describe the activity, Employee E21 stated, we play music and get the residents moving around. During an observation on 6/25/25, at 2:36 p.m. the Fourth-floor common room had six residents in the room. Activity aide Employee E21 was sitting at a table with a connect four game on the table with no residents playing game and failed to interact with the group of residents at the activity. During an interview on 6/26/25, at 1:45 p.m. Activity Director Employee E4 stated that Activity Aide Employee E21 should interact with the residents during an activity, attempted to get residents to participate and move their arms around or lift their legs, for example. During an interview on 6/26/25, at 1:53 p.m. Activity Director Employee E4 confirmed that the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for one of three floors (Fourth floor). 28 Pa. Code: 201.18 (b)(3) Management

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to follow physician orders for Blood Glucose levels for one of eight residents (Resident R50), failed to provide parameters of when to notify physicians of increased and decreased Capillary Blood Glucose (CBG) levels or notifying physician of results outside parameters ordered for five of eight residents (Residents R25, R34, R53, R75, and R120), failed to document appropriate interventions for a resident with hypoglycemia (low blood glucose) for one of eight residents (Resident R53), failed to provide therapeutic lab monitoring for one of three residents (Resident R58) and failed to ensure timely follow up physician appointments were scheduled for one out of three residents (Residents R111). Findings include: The facilities Nursing Care of the Older Adult with Diabetes Mellitus policy dated 5/20/25, indicated to provide overview of diabetes in the older adult, its symptoms and complications, and the principles of glucose monitoring. The Centers for Disease Control defines diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called blood glucose (BG) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 milligrams per deciliter (mg/dl). If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours, or a blood glucose greater than 180 mg/dL one to two hours after eating. If you have hyperglycemia and it's untreated for long periods of time, you can damage your nerves, blood vessels, tissues, and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage and non-healing wounds. The facilities Change in a Resident's Condition or Status policy dated 5/20/25, indicated the facility will promptly notify the attending physician and the resident representative of changes in the resident ' s medical change. The facilities Specimen Collection policy dated 5/2/25, indicated our facility will collect specimens in accordance with nursing service procedures. Review of Resident R50's admission record indicated resident was admitted on [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R50's Minimum Data Set (MDS - periodic assessment of resident care needs) assessment dated [DATE], indicated diagnoses of high blood pressure, diabetes (a metabolic disorder impacting organ function related to glucose levels in the human body), and depression. MDS Section N Medications N0300 coded as resident receives insulin injections. Review of Resident R50's physician orders dated 6/26/24, indicated to check blood glucose levels two times a day. Order failed to include parameters as to when to call the physician. Review of Resident R50's physician orders dated 7/22/24, indicated to administer Lantus (a long-acting medication used to treat diabetes) 12 units at bedtime. Review of Resident R50's blood glucose monitoring revealed the facility failed to obtain blood glucose levels from 10/24/24 through 6/24/25. During an interview on 6/25/25, at 12:15 p.m. Director of Nursing confirmed that the order was incorrectly taken off by nursing, failed to include parameters as to when to notify the physician, and failed to obtain blood glucose levels from 10/24/24 through 6/24/25 for Resident R50. Review of the clinical record revealed that Resident R25 was admitted to the facility on [DATE] . Review of Resident R25's MDS dated [DATE], indicated the diagnosis of anemia (low iron in the blood), diabetes (high sugar in the blood) and right leg above the knee amputation. Review of Resident R25's physician orders dated 9/9/24, indicated HumaLOG KwikPen Solution Pen-injector 100 UNIT/ML (Insulin Lispro- fast acting insulin that lowers blood sugar) Inject as per sliding scale: 0 - 70 = 0 units implement diabetic protocol and call physician: 71 - 140 = 2 units; 141 - 180 = 4 units; 181 - 220 = 6 units; 221 - 260 = 8 units; 261 - 300 = 10 units; 301 - 340 = 12 units; 341 - 500 = 14 units over 341, give 14 units and call MD, subcutaneously before meals and at bedtime. Review of resident R25's glucometer readings indicated that on 6/9/25, at 4:30 p.m. the level was 375.0 mg/ml. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident R25's progress notes failed to include notification to the physician for glucometer reading over 341. During an interview completed on 6/26/25 at 10:55 a.m. Licensed Practical Nurse (LPN) Employee E12 confirmed that the physician was not notified of increased glucometer check on 6/9/25, and stated I only see notes for 6/8/25, and 6/20/25, there are no other notes in between that time. Review of Resident R34's admission record indicated resident was admitted on [DATE]. Review of Resident R34's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). MDS Section N Medications N0300 coded as resident receives insulin injections. Review of Resident R34's physician orders dated 2/4/25, indicated to administer Humalog (a short acting medication used to treat diabetes) according to a sliding scale and notify physician if BG is less than 70 or greater than 350. Review of Resident R34's physician orders dated 6/24/25, indicated to administer Lantus five units at bedtime. Review of Resident R34's clinical records for April 2025, though May 2025, indicated the following blood glucose measurements: 4/18/25 - 377 mg/dL 5/11/25 - 400 mg/dL 5/16/25 - 400 mg/dL 5/26/25 - 369 mg/dL Review of Resident R34's progress notes from 4/18/25, through 5/26/25, failed to include documentation that a physician was notified of Resident R34's abnormal blood glucose levels on the dates listed above. During an interview on 6/25/25, at 12:20 p.m. Director of Nursing confirmed that the physician was not notified of the blood glucose readings per physician order for Resident R34. Review of Resident R53's admission record indicated resident was admitted on [DATE]. Review of Resident R53's MDS dated [DATE], indicated diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), diabetes, depression. MDS Section N Medications N0300 coded as resident receives insulin injections. Review of Resident R53's physician orders dated 4/30/25, indicated to administer Lantus 20 units at bedtime. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy Park Post Acute	5609 Fifth Avenue Pittsburgh, PA 15232

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R53's physician orders dated 6/11/25, indicated to check blood glucose levels three times a week. The order failed to indicate parameters as to when to notify the physician. Review of Resident R53's clinical records for May 2025, indicated the following blood glucose measurements: 5/2/25 - 62 mg/dL 5/7/25 - 58 mg/dL 5/14/25 - 60 mg/dL 5/16/25 - 67 mg/dL Review of Resident R53's progress notes from 5/1/25, through 5/31/25, failed to include documentation that a physician was notified of Resident R53's abnormal blood glucose levels on the dates listed above and failed to document interventions used to treat hypoglycemia. During an interview on 6/25/25, at 12:25 p.m. Director of Nursing confirmed that the physician was not notified of the abnormal blood glucose readings per physician order and failed to document interventions used to treat hypoglycemia for Resident R53. Review of Resident R75's admission record indicated resident was admitted on [DATE]. Review of Resident R75's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes, and dementia. MDS Section N Medications N0300 coded as resident receives insulin injections. Review of Resident R75's physician orders dated 1/30/25, indicated to check blood glucose levels three times a day. The order failed to indicate parameters as to when to notify the physician. Review of Resident R75's physician orders dated 3/12/25, indicated to administer Lantus 8 units at bedtime. Review of Resident R75's clinical records from 4/24/25 through 6/5/25, indicated the following blood glucose measurements: 4/24/25 - 300 mg/dL 4/25/25 - 340 mg/dL 5/5/25 - 350 mg/dL 5/22/25 - 340 mg/dL 6/5/25 - 335 mg/dL Review of Resident R75's progress notes from 4/24/25, through 6/5/25, failed to include documentation that a physician was notified of Resident R75's abnormal blood glucose levels on the dates above. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/25/25, at 12:30 p.m. Director of Nursing confirmed that the physician was not notified of the abnormal blood glucose readings per physician order and failed to include parameters as to when to notify the physician for Resident R75. Review of Resident R120's admission record indicated resident was admitted on [DATE]. Review of Resident R120's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes, and dementia. MDS Section N Medications N0300 coded as resident receives insulin injections. Review of Resident R120's physician orders failed to indicate how often to check blood glucose readings, and parameters as to when to notify the physician. Review of Resident R120's physician orders dated 4/30/25, indicated to administer Lantus 30 units at bedtime. Review of Resident R120's clinical records from 5/16/25 through 6/17/25, indicated the following blood glucose measurements: 5/16/25 - 416 mg/dL 5/26/26 - 530 mg/dL 5/30/25 - 400 mg/dL 6/6/25 - 400 mg/dL 6/15/25 - 385 mg/dL 6/17/25 - 400 mg/dL Review of Resident R120's progress notes from 5/16/25, through 6/17/25, failed to include documentation that a physician was notified of Resident R120's abnormal blood glucose levels on the dates above. During an interview on 6/25/25, at 12:35 p.m. Director of Nursing confirmed that the physician was not notified of the abnormal blood glucose readings per physician order and failed to include parameters as to when to notify the physician for Resident R120. Review of Resident R58's admission record indicated resident was admitted on [DATE]. Review of Resident R58's MDS dated [DATE], indicated diagnoses of diabetes, bipolar disorder (a mental condition marked by alternating periods of elation and depression), and heart failure (a progressive heart disease that affects pumping action of the heart muscles). Review of Resident R58's physician orders dated 11/24/24, indicated to administer Lithium Carbonate 150 mg by mouth two times a day. The physician orders failed to include therapeutic lab monitoring for Resident R58's Lithium. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/25/25, at 12:37 p.m. Director of Nursing stated resident should have been getting routine Lithium lab work and confirmed that Resident R58 did not have any orders for lab draws to monitor Lithium levels. Review of the clinical record indicated that Resident R111 was admitted to the facility on [DATE]. Review of Resident R111's MDS dated [DATE], indicated diagnosis of anxiety disorder, hypothyroidism (thyroid gland doesn ' t produce enough hormones), gastro-esophageal reflux disorder (GERD- stomach acid flows back up through the esophagus). Section C0500 Brief interview for mental status (BIMS-tool used to screen and identify the cognitive condition of a resident the score of 0-7 severely impaired cognition, 8-12 moderately impaired cognition 13-15 intact cognition) coded as 14 indicating resident has intact cognition. During an interview completed on 6/23/25, at 11:10 a.m. Resident R111 stated we have trouble with our appointments, I missed one on Friday because it was not put on the calendar, now I have to wait longer for it to be rescheduled. During an interview completed on 6/24/25 at 12:32 p.m. upon asking LPN Employee E12 concerning Resident R111's missed appointment stated, it might have been one of the days the transportation company messed up they never showed to pick her up. During an interview completed on 6/24/24 at 1:14 p.m. upon asking Medical Records (MR) Employee E24 about Resident R111's missed appointment stated Resident R111 makes her own appointments and gives it to different staff members there are too many people involved in making appointments. A lot is broken there is no communication, the staff will sometimes text me the information to schedule the transportation. The transport company needs 24-hour notice for a wheelchair transfer and 48 hours for a stretcher transport. There is no process for scheduling. Resident R111 has been rescheduled for 7/22/25. During an interview completed on 6/24/25, at 2:02 p.m. upon asking the Assistant Director of Nursing (ADON) Registered Nurse (RN) Employee E1 concerning the scheduling of resident appointments stated the process on the floor varies from person to person. If the resident has a BIMS score of 13 or above, they can arrange their own transportation and appointments. There have been a few times when an appointment is missed, we try to reschedule as soon as we can. We are working on our own transportation and confirmed that the facility failed to ensure timely physician follow up appointments were scheduled for one out of three residents (Residents R111). 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29(a) Resident Rights 28 Pa. Code 211.10 (c)(d) Resident Care policies 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, national accepted guidelines for Pressure Ulcers, and staff interview, it was determined that the facility failed to accurately assess pressure ulcers for two of five residents (Resident R4 and R94). Findings include: The facility policy Pressure ulcer/skin breakdown reviewed 5/20/25 indicated the nursing staff and practitioner will assess and document and individual's significant risk factors for developing pressure ulcers. The nurse shall describe and document the following: a. full assessment of pressure sore including location, stage, length, width, and depth and presence of extrudes or necrotic tissue b. pain assessment c. resident's mobility status d. current treatments e. all active diagnosis Review of the clinical record revealed that Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/28/25, indicated the diagnoses of coronary artery disease (reduced blood flow to the heart), hypertension (high blood pressure) and acute osteomyelitis right foot and ankle (infection in the bone). During an observation completed on 06/23/25, at 10:07 a.m. Resident R4 was in bed a wound vac (a vacuum-assisted device that uses negative pressure to pull a wound together) was on her right foot. Review of Resident R4's physician orders dated 5/27/25, indicated wound vac to be applied Monday, Wednesday and Friday to right distal amputation site. Site to be cleansed with wound cleanser and pat dry after removal. Wound vac to be changed as needed every day shift and as needed. Further review of Resident R4's clinical record 5/27/25, through 6/26/25, revealed no wound measurements for the right foot amputation site. During an interview completed on 6/27/25, at 10:14 a.m. the Director of Nursing (DON) confirmed there were no weekly measurements for the right foot amputation site. Review of the clinical record indicated Resident R94 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], indicated that Resident R94 had diagnoses that included surgical aftercare of digestive system, peritonitis (inflammation of the membrane lining the abdominal wall and covering the abdominal organs) and alcoholic cirrhosis of liver. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical admission assessment dated [DATE], indicated that Resident R94 has a pressure ulcer on the coccyx, no measurements. Further review of Resident R94's clinical record from 4/24/25 through 6/26/25, revealed no measurements. Review of physician orders dated 4/25/25 indicated Resident R94 coccyx stage 4 stage pressure to be cleansed with wound cleanser and pat dry, apply therahoney and BG daily and as needed when soiled or dislodged. During an interview on 6/26/25, at 1:35 p.m. the Assistant Director of Nursing Employee E1 confirmed the facility failed to accurately assess pressure ulcers for two of five residents as required. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, review of clinical record, and staff interview, it was determined that the facility failed to provide appropriate foot care to two of five residents (Residents R117 and R120). Findings include: The facility's Podiatry Services Policy dated 5/20/25, indicated that podiatry services will be offered on a routine basis (e.g., every six to eight weeks) through a contracted provider. Nursing staff are responsible for coordinating visit schedules and obtaining consents. Review of the admission record indicated Resident R117 was admitted to the facility on [DATE]. Review of Resident R117's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/12/25, indicated diagnoses of high blood pressure, diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life). Review of Resident R117's current care plan indicated Nurse Aide (NA) assess skin integrity daily with care and report abnormalities. Licensed nurse to conduct a comprehensive skin inspection weekly. Observation on 6/26/25, at 12:05 p.m. Resident R117 was lying in bed, with feet exposed from underneath the sheet. Observation and interview with Licensed Practical Nurse (LPN) Employee E15 on 6/26/25, at 12:45 p.m. confirmed Resident R117's toenails were thick, elongated and curved with a length that varied from approximately one-half inch to one inch over the ends of the toes. Review of Resident R120's clinical record indicated resident was admitted to the facility on [DATE]. Review of Resident R120's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes, and dementia. Section M1200 Skin and Ulcer/Injury Treatments indicated pressure ulcer/injury care. Review of Resident R120's physician orders dated 1/19/25, indicated to consult podiatry. Review of Resident R120's physician orders dated 5/21/25, indicated to cleanse right heel with wound cleanser and pat dry. Thera honey (a honey dressing used to treat wounds) to be applied to wound and place silver alginate (a medicated cream) over area and wrap with kling (a type of bandage used to secure dressing) every other day or as needed. During a wound dressing observation on 6/25/25, at 2:15 p.m. Resident R120 was sitting in a wheelchair in her room. Registered Nurse (RN) Employee E1 took bilateral socks off and Resident R120's toenails were observed. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 6/25/25, at 2:30 p.m. RN Employee E1 confirmed Resident R120's toenails were thick, long, and curved upwards. Interview on 6/26/25, at 12:58 p.m. the Director of Nursing confirmed that Resident R117 and R120 had not received Podiatry care since admission and that the facility failed to provide appropriate foot care to two of five residents (Residents R117 and R120). 28 Pa. Code 201.21(c) Use of outside resources. 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on review of facility policy, clinical records, facility documents, resident interviews, and staff interviews, it was determined that the facility failed to make certain residents with behaviors triggering elopement risk were identified timely, failed to assess on an ongoing basis, and failed to provide care plan and physician orders for interventions regarding exit seeking behaviors for three of five residents (Resident R70, R104, and R120). Findings include: Review of facility policy Elopement Risk Assessment Policy dated 5/20/25, indicated all residents will have an elopement risk assessment completed upon admission, quarterly, and with a significant change in condition, such as increased confusion, agitation, or mobility changes. If a resident is identified as an elopement risk, the care plan will include individualized interventions to address safety and monitoring. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2024, indicated that a 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 8-12: moderately impaired 0-7: severe impairment. Review of the admission record indicated Resident R70 was admitted to the facility on [DATE]. Review of Resident R70's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/18/25, indicated diagnoses of high blood pressure, anemia (too little iron in the blood),and dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life). Section C0500 indicated a BIMS score of 12 - moderately impaired. Section GG indicated resident able to wheel self independently in manual wheelchair. Review of Resident R70's current care plan indicated Resident exhibits fluctuating mood symptoms related to adjustment disorder with anxiety, dementia, sleeplessness, pain and frustration over residing in a facility. Review of Resident R70's progress note dated 5/27/25, indicated nursing states patient still often fixated on going home. Resident becomes angry when talking about it. Resident denied any pain, chest pain, shortness of breath, or abdominal pain. Resident indicated they can take care of themselves. Resident is a limited historian due to dementia. Review of Resident R70's Elopement Risk Screen dated 8/20/24, was the only Elopement Risk Screen noted in the clinical record. It indicated Resident was not at risk and did not trigger a care plan for wandering. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 6/24/25, at 10:43 a.m. Resident R70 indicated awaiting Social Services assistance to get to the next place. Interview on 6/24/25, at 11:00 a.m. Licensed Practical Nurse (LPN) Employee E13 indicated Resident R70 gets out of bed and into the wheelchair, wanders about the unit, and always talks about going home. Interview on 6/26/25, at 2:00 p.m. the Director of Nursing confirmed Resident R70's elopement risk screen was not completed quarterly as required, or when increased behaviors of wanting to go home and having the ability to wander about the unit in a manual wheelchair were not identified as triggers for elopement risk. Review of the admission record indicated Resident R104 was admitted to the facility on [DATE]. Review of Resident R104's MDS dated [DATE], indicated diagnoses of anemia (low iron on the blood), high blood pressure, and Alzheimer's disease (affects memory, thinking and behavior). Review of Resident R104's current care plan indicated Resident is at risk for elopement/exit seeking/wandering related to dementia or other cognitive behavior. Review of Resident R104's admission elopement and wandering risk observation dated 11/26/24, indicated if the total score is 10 or greater, the resident would be considered At Risk for Wandering or Elopement. Resident R104 scored a 16. Further review of Resident R104's clinical record revealed no further elopement assessments completed. During an interview completed on 6/25/25, at 1:32 p.m. the Assistant Director of Nursing (ADON) Employee E1 confirmed Resident R104's elopement risk assessment was not completed quarterly as required. Review of Resident R120's clinical record indicated resident was admitted to the facility on [DATE]. Review of Resident R120's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and dementia. During a review of Resident R120's physician orders dated 1/5/25, failed to include to check function of resident's wanderguard. During an observation on 6/24/25, at 2:15 p.m. Resident R120 was sitting in the common room and failed to have a wanderguard applied to person. During an interview on 6/24/25, LPN Employee E2 stated I checked it this morning, I don't know where its at and I don't have time to look for it right now, and confirmed that Resident R120 did not have a wanderguard on per physician order. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 6/27/25, at 12:15 p.m. the Director of Nursing confirmed the facility failed to make certain residents with behaviors triggering elopement risk were identified timely, failed to assess on an ongoing basis, and failed to provide care plan and physician orders for interventions regarding exit seeking behaviors for three of five residents (Resident R70, R104, and R120). 28 Pa. Code 211.10(c)(d) Resident Care Policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing Services 28 Pa. Code: 201.18(b)(1) Management.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record and staff interview it was determined that the facility failed to make certain consistent dialysis communication was maintained for two of three residents (Residents R2 and R21) and failed to maintain a current dialysis contract with dialysis vendor for two of three (Resident R2, and R61). Findings include: Review of the facility policy End-Stage Renal Disease (ESRD), Care of a Resident with dated 5/20/25, indicated agreements between this facility and the contracted ESRD facility include all aspects of how the resident ' s care will be managed, including: a. how the care plan will be developed and implemented; b. how information will be exchanged between the facilities; and c. responsibility for waste handling, sterilization and disinfection of equipment. Review of the admission record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/12/25, indicated diagnoses of high blood pressure, anemia (too little iron in the blood), and renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids). Review of Resident R2's physician orders dated 6/18/25, indicated dialysis: Monday, Wednesday, and Friday at dialysis vendor. Pick up time at 5:30 a.m. and chair time at 6:30 a.m. Review of Resident R2's current care plan indicated dialysis: Monday, Wednesday, and Friday at dialysis vendor. Pick up time at 5:30 a.m. and chair time at 6:30 a.m. Review of Resident R2's dialysis communication forms indicated the following: -June 2025, failed to be present. -May 2025, had one incomplete form dated 5/28/25. No other forms were present. -April 2025, had one incomplete form with the starting date of 4/2/25, and the ending date of 4/12/25. No other forms were present. -March 2025, had one incomplete form dated 3/19/25. No other forms were present. -February 2025, had one incomplete form dated 2/14/25. No other forms were present. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 6/23/25, at 1:00 p.m. Licensed Practical Nurse (LPN) Employee E22 confirmed the sheets failed to be present and complete as listed. Review of the admission record indicated Resident R21 was admitted to the facility on [DATE]. Review of Resident R21's MDS dated [DATE], indicated the diagnosis of high blood pressure, diabetes (high sugar in the blood) and end stage renal disease (final stage of chronic kidney disease, kidneys can Review of Resident R21's physician orders dated 6/18/25, indicated dialysis: Tuesday, Thursday, and Saturday at dialysis vendor. Pick up 10:00 a.m. and chair time 12:00 p.m. Review of Resident R21's current care plan indicated dialysis Tuesday, Thursday, and Saturday at dialysis vendor. Pick up 10:00 a.m. Review of Resident R2's dialysis communication forms indicated the following: -June 2025, had two complete forms 6/3/25, and 6/17/24. One incomplete form dated 6/19/25. No other forms were present. -May 2025, had three complete forms dated 5/6/25, 5/15/25 and 5/27/25. One incomplete form dated 5/24/25. No other forms were present. -April 2025, had three complete forms dated of 4/1/25, 4/3/25, and 4/22/25. One incomplete form dated 4/22/25. No other forms were present. During an interview completed on 6/26/25, at 10:48 a.m. Licensed Practical Nurse Employee E12 confirmed the sheets failed to be present and complete as listed and stated, we just started the books a few weeks ago. Review of the admission record indicated Resident R61 was admitted to the facility on [DATE]. Review of Resident R61's MDS dated [DATE], indicated diagnoses of high blood pressure, anemia, and renal insufficiency. Review of Resident R61's physician orders dated 6/18/25, indicated dialysis: Monday, Wednesday, and Friday at dialysis vendor. Pick up time at 9:00 a.m. and chair time at 10:00 a.m. Review of Resident R61's current care plan indicated dialysis: Monday, Wednesday, and Friday at dialysis vendor. Review of the facility provided dialysis agreements failed to include an agreement for dialysis vendor for Resident R2 and Resident R61 as required. Interview with the Nursing Home Administrator confirmed the facility did not have a current contract with Resident R2's and Resident R61's dialysis vendor as required. (continued on next page)

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	395251	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy Park Post Acute	5609 Fifth Avenue Pittsburgh, PA 15232

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 6/27/25, at 12:15 p.m. the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to make certain consistent dialysis communication was maintained for two of three residents (Residents R2 and) and failed to maintain a current dialysis contract with dialysis vendor for two of three (Resident R2, and R61) as required. 28 Pa. Code: 211.5(f) Clinical records 28 Pa. Code: 211.12(d)(2)(3) Nursing services

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident record review, and staff interviews, it was determined that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for one of four residents (Resident R125). Findings include: Review of the facility policy Trauma Informed Care and Culturally Competent Care last reviewed 5/20/25, indicated to guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice. To address the needs of trauma survivors by minimizing triggers and/or re-traumatization. General guidelines that include but not inclusive to: Resident Care Planning develop individualized care plans that address past trauma in collaboration with the resident and family. Identify and decrease exposure to triggers that may re-traumatize the resident Review of the clinical record indicated Resident R125 was admitted to the facility on [DATE]. Review of Resident R125's Minimum Data Set (MDS - a periodic assessment of resident care needs) dated 5/28/25, indicated diagnoses of post-traumatic stress disorder (PTSD-a mental health condition in people who have experienced or witnessed a traumatic event), anemia (low iron in the blood) and hip fracture. Review of Resident R125's care plan dated 5/22/25, indicated -Trauma-informed Care: At risk for decreased psychosocial well-being and adjustment issues, emotional distress and ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social, or spiritual wellbeing related to assault with a weapon but failed to identify what the triggers were and how to avoid them. Interview completed 6/26/25, 11:10 a.m. Social Services Director Employee E23 confirmed that the facility failed to identify PTSD triggers for Resident R125 in order to eliminate or mitigate any triggers that may cause re-traumatization for the resident. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of personnel records and staff interview it was determined that the facility failed to complete annual performance evaluations for three of five nurse aides (NA Employee E17, E18 and E19). Findings include: Review of personnel files revealed that Nurse Aide Employee E17 last hire date was 9/27/17, last performance evaluation was completed 12/28/18-12/29/19. Review of personnel files revealed that Nurse Aide Employee E19 last hire date was 4/20/05 , last performance evaluation was completed 7/20/20-7/19/21 . Review of personnel files revealed that Nurse Aide Employee E18 last hire date was 3/27/23, there was no performance evaluations was completed in file. During an interview on 6/27/25, at 8:15 a.m. Human Resource Employee E16 confirmed that the facility does not have up to date performance appraisals completed on NA Employee E17, E18 and E19 as required. 28 Pa Code: 201.20 (a)(b)(c)(d) Staff development. 28 Pa Code: 201.14 (a) Responsibility of licensee.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to store medications properly and securely in two of three medications carts (Third floor Low Cart, and Second floor Low Cart). Findings include: Review of the facility policy Medication Storage dated 5/20/25, indicated all drugs and biologicals will be stored in locked compartments. Certain medications or package types, such as multiple dose and ophthalmic (eye) solutions require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency. During an observation on 6/23/25, at 11:48 a.m. the Second floor Low Cart contained the following undated medications: -ipratropium nebulizer medication (used to treat respiratory conditions by relaxing muscles around the airways to make breathing easier - a drug delivery device used to administer medications in the form of a mist) three packages opened without a date as required. -Ellipta (a type of dry powder inhaler used for treating respiratory disease) one inhaler opened without a date as required. During an interview on 6/23/25, at 11:49 a.m. Licensed Practical Nurse Employee E11 confirmed that the medications were opened and not dated as required. During an observation on 6/25/25, at 10:40 a.m. the Third floor Low Cart contained the following undated medications: -Ketotifen Fumarate eye drop vial (used to relieve the itching of eyes due to pollen, ragweed, grass, animal hair, and dander) opened and dated January 28, 2025. During an interview on 6/25/25, at 10:41 a.m. LPN Employee E12 confirmed the eye medication was opened and past use by date. Interview on 6/27/25, at 12:15 p.m., the Director of Nursing confirmed that the facility failed to properly and securely store medications in two of three medications carts (Third floor Low Cart, and Second floor Low Cart). 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(2)(3) Nursing services.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, observation, and staff interviews, it was determined that the facility failed to provide drinks in a form to meet individuals' needs in one of four residents (Resident R48). Findings include: Review of the facility policy Therapeutic Diets dated 5/20/25, indicated that therapeutic diets are prescribed by the attending physician to support the resident ' s treatment and plan of care and in accordance with his or her goals and preferences. A therapeutic diet must be prescribed by the resident's physician. Review of the clinical record revealed that Resident R48 was admitted to the facility on [DATE]. Review of Resident R48's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 5/8/25, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and dysphagia (difficulty swallowing). Section K Swallowing Nutritional Status K0520 C indicated mechanical altered diet and was check marked -while a resident. Review of Resident R48's physician's orders on 11/21/24, indicated that resident was ordered thickened liquids, nectar consistency, no straws. Review of Resident R48's care plan dated 3/14/25, indicated to provide diet as ordered. Nectar thick consistency, no straw. Review of Resident R48's Kardex (plan of care that is available for staff to follow) indicated Eating/Nutrition - Nectar thick consistency, No straw. During an observation on 6/25/25, at 9:07 a.m. Resident R48 was observed laying in his bed with a white Styrofoam cup with clear thin liquids with a straw on his bedside table, within reach. During an interview on 6/25/25, at 9:10 a.m. Registered Nurse Employee stated Resident R48 should not have had that type of drink given to him and that the Nursing Assistant who passed it out failed to look at his ordered diet. During an interview on 6/25/25, at 2:35 p.m. the Director of Nursing confirmed that the facility failed to provide drinks in a form to meet individuals' needs in one of four residents (Resident R48). 28 Pa. Code: 201.18(b)(3) Management 28 Pa Code: 211.10(c) Resident Care Policies

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility policy, observations and staff interview, it was determined that the facility failed to properly store food products in the walk in cooler and reach in cooler which created the potential for cross contamination (Main Kitchen). Findings include: Review of facility policy Food Receiving and Storage dated 5/20/25 indicates foods shall be received and stored in a manner that complies with safe food handling practices. During an observation of the main designated kitchen on 6/23/25, at 9:15 a.m. the following was observed: Walk in cooler: -cinnamon bread(3)-no date -bagels(2)-no date -deli ham (3)-no date or label Reach in cooler -salads(3)- no label or date -sandwiches(5)-no label or date During an interview on 6/23/25, at 10:00 a.m. Dietary Manager Employee E20 confirmed that the facility failed to properly store food products and maintain sanitary conditions which created the potential for food borne illness and cross contamination in the Main Kitchen. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(3) Management.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on review of facility policy, observation and staff interview it was determined that the facility failed to properly contain and dispose of garbage in two of three outside dumpsters to prevent the potential for rodent and insect infestation (dumpster one and two). Findings include: Review of facility policy Dumpster Area dated 5/20/25 indicates area will be a clean, safe, and complaint waste disposal area that minimizes infection risks, deters pests, and adheres to Department of Health, Department of Environmental Protection, and local sanitation regulations. During an observation of the facility's outdoor trash receptacles on 6/23/25, at 10:30 a.m. Dietary Manager Employee E20 confirmed that the lid/cover was not closed on dumpster one and two and that there was liquid from the dumpster area collecting in the disposal area. 28 Pa. Code 201.18(b)(3) Management.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, resident clinical records and staff interviews it was determined that the facility failed to ensure residents had the capacity to understand the terms of a binding arbitration agreement (A binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not.) for two of five residents (Resident R97 and Resident R104). Findings include: Review of the admission record indicated Resident R97 was admitted to the facility on [DATE]. Review of Resident R97's Binding Arbitration Agreement indicated that the resident signed the document on 4/4/25. Review of Resident R97's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/10/25, indicated the diagnoses of high blood pressure, dysphagia (difficulty swallowing), and dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life). Section C0500 BIMS (Brief Interview for Mental Status - a screening test that aides in detecting cognitive impairment) indicated a score of six (score 0-7: severe impairment). Review of the admission record indicated Resident R104 was admitted to the facility on [DATE]. Review of Resident R104's Binding Arbitration Agreement indicated that the resident signed the document on 11/27/24. Review of Resident R104's MDS dated [DATE], indicated the diagnoses of high blood pressure, dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), and anemia (the blood doesn ' t have enough healthy red blood cells). Section C0500 BIMS indicated a score of three (score 0-7: severe impairment). Interview on 6/24/25, at 1:11 p.m. the Nursing Home Administrator confirmed the facility failed to ensure a resident had the capacity to understand the terms of a binding arbitration agreement for two of five residents (Resident R97 and R104). 28 Pa. Code: 201.18(e)(1) Management

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review, observation, and staff interviews, it was determined that the facility failed to prevent cross contamination during a dressing change for one of three residents (Resident R120). Findings include: Review of the facility policy Wound Care dated 5/20/25, indicated the purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Review of Resident R120's clinical record indicated resident was admitted to the facility on [DATE]. Review of Resident R120's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 5/8/25, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Section M1200 Skin and Ulcer/Injury Treatments indicated pressure ulcer/injury care. Review of Resident R120's physician orders dated 5/21/25, indicated to cleanse right heel with wound cleanser and pat dry. Thera honey (a honey dressing used to treat wounds) to be applied to wound and place silver alginate (a medicated cream) over area and wrap with kling (a type of bandage used to secure dressing) every other day or as needed. During a wound dressing change observation on 6/25/25, at 2:01 p.m. completed by Registered Nurse (RN) Employee E1, the following observations were made: - RN Employee E1 failed to clean the surface being used to hold supplies being used prior to dressing change - No barrier was laid down under residents ' foot during dressing change - Scissors were taken out of pocket and used without cleaning them prior to use - After cutting off soiled dressing, RN Employee E1 laid the dirty dressing on the floor with empty dressing packaging - RN Employee E1 failed to clean the surface being used to hold supplies being used after completion of dressing change During an interview on 06/25/25, at 2:45 p.m. RN Employee E1 confirmed the above observations and confirmed that the facility failed to prevent cross contamination during a dressing change for one of three residents (Resident R120). 28 Pa. Code: 211.10(d) Resident Care Policies. 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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on a review of select facility policy and staff interview, it was determined the facility failed to designate a qualified individual(s) onsite, who is responsible for implementing programs and activities to prevent and control infections (7/1/24 to 9/30/24). Findings included: During a review of facilities Infection Control Committee meetings for the third quarter, the facility failed to provide signatures of attendees for July, August, and September 2024 infection control committee meeting. During an interview on 6/26/25, at 2:11 p.m. the Director of Nursing (DON) stated, Infection Preventionist (IP) Employee E5 was on leave of absence for the above months and was unable to provide an IP certificate who was completing the Infection Preventionist role during her leave of absence. During an interview on 6/26/25, at 2:40 p.m. the DON confirmed that the facility failed to designate a qualified individual(s) onsite, who is responsible for implementing programs and activities to prevent and control infections from 7/1/25, to 9/30/24. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 201.19(3) Personnel records. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of facility policy, personnel records, and staff interview it was determined that the facility failed to ensure that three of five sampled Nurse Aides (NA) received a minimum of 12 hours of in-service education per year (NA Employees E17, E18 and E19). Review of faciliy policy In-Service Training-All Staff dated 5/20/25 indicated all staff must participate in initial orientation and annual in-service training. Review of facility nurse aide training records revealed that nurse aide Employees E17, E18 and E19 did not receive 12 hours of in-service training in the last year. The facility was unable to provide documented evidence that the above nurse aide employees had received a minimum of 12 hours of in-service training yearly. During an interview on 6/25/25 , at 1:15 p.m. Human Resource Employee E16 confirmed that the facility did not have evidence that NA Employee E17, E18 and E19 received the required 12 hours of yearly in-service training. 28 Pa. Code: 201.14(a) Responsibility of Licensee. 28 Pa. Code: 201.20(c) Staff Development.