

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2025
NAME OF PROVIDER OR SUPPLIER Champion City Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6655 Frankstown Avenue Pittsburgh, PA 15206	
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 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 policies, clinical records, facility documents and staff interviews, it was determined that the facility failed to ensure residents were assessed, and provided necessary treatment and services, consistent with professional standards of practice, for a pressure ulcer (PU/Pls- injuries to skin and underlying tissue resulting from prolonged pressure on the skin) for one of three residents (Resident R1). Findings include: Review of facility policy Wound Care dated 10/30/25, indicated the purpose is to provide guidelines for the care of wounds to promote healing. Verify that there is a physician's order for the procedure. Review the resident's care plan to assess for any special needs of the resident. The following information should be recorded in the resident's medical record: Type of wound care given. The date and time the wound care was given. The position in which the resident was placed. The name and title of the individual performing the wound care. Any changes in the resident's condition. All assessment data (i.e., wound bed color, size, drainage, etc) obtained when inspecting the wound. How the resident tolerated the procedure. Any problems or complaints made by the resident related to the procedure. In the resident refused the treatment and the reason(s) why. The signature and title of the person recording the data. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], recently readmitted [DATE]. Review of Resident R8's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/8/25, indicated diagnoses metabolic acidosis (condition characterized by an excess of acid on the blood), pulmonary embolism (condition that occurs when a blood clot blocks blood flow the lungs), and high blood pressure. Section M - Skin Condition, M0300C indicated a 1 = Number of Stage 3 pressure ulcers, and M0300D indicated a 1 = Number of Stage 4 pressure ulcers. Review of Resident R1's clinical Skin/Wound progress note dated 12/15/25, revealed that Left gluteal fold is a Stage 3 Pressure ulcer, not healed, measurements 0 cm (centimeters) length x 0 cm width, and with no measurable depth, area closed, wound is improving; Right gluteal fold is a Stage 4 Pressure ulcer, not healed, measurements 5.4 cm length, 4.7 cm width, and 0.5 cm depth, wound is improving. Resident of Resident R1's physician order dated 11/7/25, discontinued 12/16/25, indicated to cleanse left ischial with NSS (normal saline solution = sterile water), pat dry, apply Medihoney (medical grade honey product that supports wound healing) and cover with a dry dressing daily and PRN (as needed) for soilage and/or dislodgement every day shift for wound care. Review of an additional physician order dated 11/23/25, discontinued 12/16/25, indicated to cleanse right ischial with NSS, pat dry, apply calcium alginate (wound care product derived from seaweed to enhance autolytic debridement) and cover with a dry dressing daily and PRN for soilage and/or dislodgement every day shift for wound care. Review of Resident R1's current plan of care for pressure areas, initiated 11/7/25, indicated to administer treatments as ordered and monitor for effectiveness Review of Resident R1's Treatment Administration Record (TAR) from 12/1/25, through 12/16/25, revealed no documentation of refusals of dressing changes and revealed the following dates without wound treatment documented as completed: 12/3/25, 12/9/25, 12/10/25, 12/11/25, 12/12/25, 12/14/25, and 12/15/25 Review of Resident R1's s progress notes failed to reveal documentation of a reason for the dressings not to have been completed. During an interview on 12/23/25, at 1:00 p.m., the Director of Nursing (DON) confirmed (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that dressing changes for Resident R1 were not documented as completed and revealed that the wound nurse may have been off and/or pulled to a cart to pass medication, and coverage for daily wound care was not communicated effectively to staff for coverage. During an interview on 12/23/25, at 2:20 p.m., the Nursing Home Administrator (NHA) and the DON confirmed that the facility failed to ensure residents were assessed, and provided necessary treatment and services, consistent with professional standards of practice, for a pressure ulcer (PU/PIs- injuries to skin and underlying tissue resulting from prolonged pressure on the skin) for one of three residents (Resident R1). 28 Pa. Code 201.18 (b)(1) Management.28 Pa. Code 211.10 (c)(d) Resident care policies.28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.		