

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2025
NAME OF PROVIDER OR SUPPLIER Carnegie Park Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1848 Greentree Road Pittsburgh, PA 15220	

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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**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 residents are free of significant medication errors for one of three residents (Resident R1).</p> <p>Review of facility policy Medication Monitoring dated 3/14/25, indicated staff monitor and document events including medication error.</p> <p>Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE].</p> <p>Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 3/12/25, included diagnoses of peritoneal abscess (abscess near the large bowel), colitis (inflammation in the colon), and high blood pressure.</p> <p>Review of the provider orders reveal the residents Total Parenteral Nutrition (TPN) is to run a cycle for twelve hours from 9 p.m. to 9 a.m. daily.</p> <p>Review of the clinical record on 5/9/25 revealed Resident R1 received the incorrect TPN. This was reportedly discovered and hour later when Resident R4 was to have TPN prepared and administered. The infusion was stopped, the provider was notified.</p> <p>During an interview with the Resident R1 on 5/29/25 at 11:30 a.m., she reported no ill effects or concerns with her daily TPN infusions.</p> <p>During an interview on 5/29/25 at 2:20 p.m., Licensed Practical Nurse (LPN) Employee E1 confirmed the wrong TPN was administered to the resident.</p> <p>During an interview with LPN Employee E1 on 5/29/25 at approximately 2:20 p.m., stated the TPN was administered by the shift supervisor, Registered Nurse (RN) Employee E2 on 5/10/25. The TPN is to run a cycle for twelve hours from 9 p.m. to 9 a.m. At approximately 5:00 a.m. the infusion pump read complete, and the pump stopped the infusion with medication remaining. The pump was reported to be set at the incorrect rate.</p> <p>Review of employee statement 5/29/25 at 2:46 p.m. RN Employee E 3 confirmed she mixed the incorrect TPN.</p> <p>(continued on next page)</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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the TPN storage on 5/29/25 at 3:30 p.m. revealed the TPN products are packaged, labeled, sealed, and in a dedicated bin for the individual residents on TPN.</p> <p>Review of the facility record on date 5/11/25 revealed Resident R1 did not receive the complete dose of TPN.</p> <p>During an interview on 5/29/25 at approximately 2:50 p.m., with the Assistant Director of Nursing the investigation concluded that the pump was set at the incorrect rate.</p> <p>During an interview on 5/29/25, at approximately 4:30 p.m. the Nursing Home Administrator and the Assistant Director of Nursing confirmed the facility failed to make certain that residents are free of significant medication errors for two of three residents.</p>		