

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395773	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/16/2024
NAME OF PROVIDER OR SUPPLIER  East End Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  745 North Highland 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)		
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469</b></p> <p>Based on review of facility policy, observation, and staff interviews it was determined that the facility failed to maintain the confidentiality of residents' medical information on one of two medication carts (3 South medication cart).</p> <p>Findings include:</p> <p>A review of the state operations manual dated 8/8/24, Resident Rights section S483.10(h) Privacy and Confidentiality: The resident has a right to personal privacy and confidentiality of his or her personal and medical records.</p> <p>A review of the facility policy General Dose Preparation and Medication Administration dated 4/1/24, indicates observe each resident's privacy and rights in accordance with applicable law (e.g. knocking before entering, pulling the privacy curtains, informing resident what is to occur before administration, blocking unnecessary access to the MAR).</p> <p>During an observation on 10/1/24, at 9:01 a.m. the medication cart outside of resident room [ROOM NUMBER], in the corridor, was left unattended with a resident listing with identifiable and personal information so any passer by could see.</p> <p>During an interview on 10/1/24, at 10:05 a.m. Registered Nurse (RN) Employee E1 confirmed the facility failed to maintain the confidentiality of residents identifiable and personal information on one of two medication carts (3 South medication cart).</p> <p>28 Pa. code: 211.5(b) Clinical records</p> <p>28 Pa. Code: 201.29(i) Resident Rights</p> <p>28 Pa. Code: 211.12(d)(3) Nursing Services</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35785</p> <p>Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to notify physicians of increased and decreased Capillary Blood Glucose (CBG) levels as per physician's order and failed to document appropriate interventions for a resident with hypoglycemia (low blood glucose), for two of four sampled residents (Residents R30 and R63).</p> <p>Findings include:</p> <p>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 glucose) 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.</p> <p>The facility Diabetes protocol policy dated 4/1/24, indicated the provider and staff will work together and give appropriate treatment to manage diabetes. The staff will identify and report complications such as foot infections, pressure injury, increased thirst, or hypoglycemia.</p> <p>The facility Hypoglycemia Policy policy dated 4/1/24, indicated once acute hypoglycemia has resolved, notify the provider and document in resident's medical record.</p> <p>Review of Resident R30's admission record indicated he was originally admitted on [DATE].</p> <p>Review of Resident R30's MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 8/20/24, indicated that he had diagnoses that included chronic kidney disease (a loss of kidney function resulting in the swelling of feet, fatigue, high blood pressure and changes in urination), diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), hypertension (a condition impacting blood circulation through the heart related to poor pressure), and hyperlipidemia (elevated lipid levels within the blood). These diagnoses were the most recent upon review.</p> <p>Review of Resident R30's care plan dated 6/2/24, indicated he had a history of hypoglycemia.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R30's physician orders dated 6/7/24, indicated to administer insulin (lispro) subcutaneously with blood glucose monitoring, provide medication when meal is in front of resident/hold if meal is missed, and provide insulin three times per the following protocol:</p> <p>0-70= call doctor</p> <p>71-150 = 0 units</p> <p>151-200 = 1 units</p> <p>201-250 =2 units</p> <p>251-300 = 3 units</p> <p>301-350 = 4 units</p> <p>351-400 = 6 units</p> <p>if greater than 400= 10 units and call MD</p> <p>Review of Resident R30's vitals records from June 2024 to July 2024, indicated the following blood glucose measurements:</p> <p>6/13/24= 468 mg/dl</p> <p>7/20/24= 443 mg/dl</p> <p>Review of Resident R30's clinical records and physician documents did not include notifications to the physician as ordered related to the abnormal blood glucose levels on 6/13/24 and 7/20/24.</p> <p>During an interview on 10/3/24, at 10:27 a.m. the Assistant Director of Nursing (ADON) Employee E5 failed to notify physicians of increased and decreased Capillary Blood Glucose (CBG) levels as per physician's order for Resident R30 as required.</p> <p>Review of Resident R63's admission record indicated he was originally admitted on [DATE].</p> <p>Review of Resident R63's MDS assessment dated [DATE], indicated diagnoses that included anemia (low iron in the blood), diabetes (high sugar in the blood), and hypertension (high blood pressure).</p> <p>Review of Resident R63's care plan dated 9/26/24, indicated resident has impaired glucose tolerance related to diabetes.</p> <p>Review of R63's physician orders dated 7/20/24, indicate Insulin (lispro) subcutaneous insulin pen amount per sliding scale before meals and at bedtime:</p> <p>Blood Sugar is 151 to 200, give 2 Units.</p> <p>Blood Sugar is 201 to 250, give 4 Units.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Blood Sugar is 251 to 300, give 6 Units.</p> <p>Blood Sugar is 301 to 350, give 8 Units.</p> <p>Blood Sugar is 351 to 500, give 10 Units. If Blood Sugar is greater than 500, call MD.</p> <p>Review of Resident R63's clinical record indicated on 8/28/24, a glucometer check was completed at 6:07 a. m. reading 63.</p> <p>Review of Resident R63's clinical records and physician documents did not include clinical interventions and notification to the physician related to the abnormal blood glucose levels of 63 on 8/24/24.</p> <p>During an interview completed on 10/02/24, at 2:04 p.m. Licensed Practical Nurse (LPN) Employee E2 stated low blood sugar is not included in the order parameter for to call physician, over 500 would be high, the order is only built to address the hyperglycemia. We know to call if less than 70.</p> <p>During an interview completed on 10/02/24 at 2:16 p.m. Registered Nurse (RN) Employee E3 stated some are on straight standard orders they are maintained, everybody that has the sliding scale if below or above would call the doctor, every nurse knows to call the doctor.</p> <p>During an interview on 10/03/24, at 10:14 a.m. the ADON Employee E5 stated It depends on the order or if they are symptomatic example if they are over 500, we have an order, there is not always order for hypoglycemia it depends on the symptoms if they are having an issue, if below 70 are considered hypoglycemic. Nurses report to the supervisors. I would have to look it up in the policy. Not everyone has orders for hypoglycemia we use the ongoing education, I think it's in the Relias training. Residents who have hyperglycemia have orders; hypoglycemia are treated as a nursing measure. It should be documented along with the interventions, anything under 70. ADON Employee E5 confirmed the facility failed to document appropriate interventions for a resident with hypoglycemia and failed to notify physicians of a decreased Capillary Blood Glucose (CBG) levels for Resident R63 as required.</p> <p>28 Pa. Code 201.18 (b)(1) Management</p> <p>28 Pa. Code 201.29(a) Resident Rights</p> <p>28 Pa. Code 211.10 (c)(d) Resident Care policies</p> <p>28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35785</p> <p>Based on review of facility policy, resident clinical records, and staff interviews, it was determined that the facility failed to properly assess pressure ulcers and update wound treatments for one of three sampled residents (Residents R30).</p> <p>Findings include:</p> <p>The facility Skin and wound management policy dated 9/19/24, indicated that skin care and pressure injury prevention includes providing routine skin care, conducting a full body assessment upon admission, offload heels for at risk residents, licensed nurse will complete a weekly skin check.</p> <p>Review of Resident R30's admission record indicated he was originally admitted on [DATE].</p> <p>Review of Resident R30's MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 8/20/24, indicated that he had diagnoses that included chronic kidney disease (a loss of kidney function resulting in the swelling of feet, fatigue, high blood pressure and changes in urination), diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), hypertension (a condition impacting blood circulation through the heart related to poor pressure), and hyperlipidemia (elevated lipid levels within the blood). These diagnoses were the most recent upon review.</p> <p>Review of Resident R30's care plan dated 6/3/24, indicated he had a history of skin impairment, assess the pressure ulcer area (length, width, and depth), presence/absence of granulation tissue and condition of surrounding skin weekly.</p> <p>Review of Resident R30's physician orders dated 6/3/24, indicated to provide skin wipe to both heels.</p> <p>Review of Resident R30's wound assessment dated [DATE], indicated he had an unstageable deep tissue injury to his right heel measuring 4 c.m. x 3.5 c.m. x 0 c.m.</p> <p>Review of Resident R30's clinical nurse notes dated 6/5/24, indicated Resident R30 had blood in urine and complaints of abdominal pain. Physician called and ordered he be sent to the emergency room .</p> <p>Review of Resident R30's clinical nurse notes dated 6/7/24, indicated that Resident R30 returned from the hospital.</p> <p>Review of Resident R30's physician orders did not include continued wound treatments for the right heel wound until 6/19/24.</p> <p>Review of Resident R30's wound assessments, clinical nurse progress notes, and physician notes did not include measurements of the right heel wound for the week of 6/12/24.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/3/24, at 10:39 a.m. Registered Nurse (RN) Employee E10 stated that there was a wound consultant for the facility, and she did not see wound assessment for the week of 6/12/24.</p> <p>During an interview on 10/4/24, at 11:22 a.m. Licensed Practical Nurse Assessment Coordinator (LPNAC) Employee E11 stated the following: he came back around June 2024. Before discharge, there was a right heel treatment order in on 6/5/24 and then there is a right heel treatment dated 6/19/24.</p> <p>During an interview on 10/4/24, at 11:40 a.m. the Director of Nursing (DON) confirmed that the facility failed to properly assess pressure ulcers weekly and update wound treatments for Resident R30 as required.</p> <p>28 Pa. Code 201.18 (b)(1) Management</p> <p>28 Pa. Code 201.29(d) Resident Rights</p> <p>28 Pa. Code 211.10 (c)(d) Resident Care policies</p> <p>28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services</p>

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35785</p> <p>Based on review of facility policy, resident clinical records, resident and staff interview, it was determined that the facility failed to provide adequate and timely podiatry care treatment for one of two residents (Resident R85).</p> <p>Findings include:</p> <p>The facility Admissions agreement: services of other providers policy dated 4/1/24, indicated that the facility will provide basic services. Routine personal hygiene services include nail hygiene services. The resident may receive services from outside providers in the facility, so long as the outside provider is properly licensed and certified under the law.</p> <p>Review of Resident R85's admission record indicated he was originally admitted on [DATE].</p> <p>Review of Resident R85's MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 8/5/24, indicated he had diagnoses that included sarcoidosis (an abnormal collection of cells in the lungs and lymph nodes), chronic obstructive pulmonary disease (COPD: a disease characterized by persistent respiratory symptoms involving breathlessness, coughing, and obstructed airflow to the lungs), chronic pain syndrome, and history of urinary tract infection (infection in any part of the kidneys, bladder or urethra) . These are the most current diagnoses upon review.</p> <p>Review of Resident R85's care plan dated 8/29/24, indicated that Resident R85 was at risk of skin breakdown.</p> <p>Review of Resident R85's podiatry visit assessment dated [DATE], indicated Resident R85 had history of Onychomycosis (fungal infection to the nail bed) and skin on his feet was dry, scaly.</p> <p>Review of residents that received facility podiatry services from April 2024 to September of 2024 did not include Resident R85.</p> <p>Review of Resident R85's physician orders and treatments did not include any alternative treatment for Resident R85 feet.</p> <p>During an interview on 9/30/24, at 12:15 p.m. Resident R85 stated: I have a foot fungus.</p> <p>During observations on 9/30/24, at 12:15 p.m. Resident R85 left foot was observed and the left foot skin appeared dry and cracked. Left foot big toe nail appearing to need trimmed.</p> <p>During observations on 10/3/24, at 11:02 a.m. observations of Resident R85's feet were found cracked, and dry.</p> <p>During an interview on 10/3/24, at 11:03 a.m. Resident R85 stated: I have not seen the podiatrist in three moths. I refused the antifungal pills. I take too many pills already.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/3/24, at 11:05 a.m. License Practical Nurse (LPN) Employee E9 stated that Resident R85 had no treatments for his feet and confirmed that the facility failed to provide adequate and timely podiatry care for Resident R85.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50075</p> <p>Based on review facility policies, observations, clinical records, and staff interviews it was determined that the facility failed to make certain that appropriate treatments and services were provided for the use of a urinary catheter as required for one of two residents (Resident R84).</p> <p>Findings include:</p> <p>Review of facility policy Indwelling Urinary Catheter Care Procedure dated 6/1/24, indicated that clinical staff with demonstrated competence may provide urinary catheter care. Such care will help to prevent catheter associated urinary infections and prolong the life of the catheter system. Ensure drainage bag is covered with a privacy-dignity cover.</p> <p>Review of Resident R84's clinical record indicated the resident was admitted to the facility on [DATE].</p> <p>Review of Resident R84's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 9/25/24, indicated diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Section H-Bladder and Bowel indicated the utilization of a suprapubic catheter (a special catheter that drains urine from the bladder through a small incision in the lower abdomen into a bag).</p> <p>Review of the clinical record revealed that Resident R84 had a physician's order dated 8/16/24, for suprapubic catheter for neurogenic bladder (urinary bladder problem due to disease or injury of central nervous system or nerves in the control of urination).</p> <p>During an observation on 9/30/24, at 12:10 p.m. Resident R84 was observed sitting in his wheelchair beside his bed with his urinary catheter bag connected to his chair without a privacy-dignity bag.</p> <p>During an interview on 9/30/24, at 12:20 p.m. Registered Nurse Employee E1 confirmed that Resident R84 did not have a privacy-dignity bag on his catheter drainage bag.</p> <p>During an interview on 10/1/24, at 3:15 p.m. the Director of Nursing confirmed that the facility failed to make certain that appropriate treatments and services were provided for the use of a urinary catheter as required for one of two residents (Resident R84).</p> <p>28 Pa Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa code: 211.10 (c)(d) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075</b></p> <p>Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for two of four residents (Resident R16 and R46).</p> <p>Findings include:</p> <p>Review of facility policy Oxygen Administration dated 4/1/24, indicated licensed clinicians with demonstrated competence will administer oxygen via the specified route as ordered by the provider. Verify provider order. Cleaning: Change oxygen tubing weekly and document accordingly to facility policy.</p> <p>Review of facility policy Non-Invasive Positive Pressure Policy dated 4/1/24, indicated the facility will provide the machines. A licensed clinician trained in the proper setup procedure will make noninvasive positive pressure ventilation setting adjustments and provide ongoing assessment and documentation of the patient ' s condition. Cleaning: Cleanse hose weekly with soap and tap water-air dry. Wash mask with soap and water after each use, let air dry. Once dry store mask in a plastic bag to keep it clean.</p> <p>Review of the clinical record indicated Resident R16 was admitted to the facility on [DATE].</p> <p>Review of Resident R16's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/8/24, indicated diagnoses of hypertension (high blood pressure), depression, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Section O0100, Oxygen therapy was marked.</p> <p>Review of a physician's active orders dated 8/6/24, indicated to administer oxygen via nasal cannula (a medical device that provides supplemental oxygen to patients through two prongs inserted into the nostrils) continuously at 3 liters per minute. Change oxygen tubing every seven days.</p> <p>Review of physician's active orders dated 8/6/24, indicated to administer Ipratropium-albuterol solution (used to help control the symptoms of lung disease via nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) every four hours, as needed, for chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness).</p> <p>Review of physician's active orders dated 9/5/24, indicated Continuous Positive Airway Pressure (CPAP) at bedtime, pressure 20. Special instructions: put distilled water in the chamber and start machine.</p> <p>During an observation on 9/30/24, at 12:20 p.m. Resident R16 was laying in her bed receiving 3 liters per minute of oxygen via nasal cannula. No date was present on the oxygen nasal cannula. The nebulizer hose and mouthpiece that is connected to the nebulizer machine and CPAP mask was laying on the bedside nightstand and failed to be stored in a bag, when not in use.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/30/24, at 12:25 p.m. Registered Nurse (RN) Employee E1 confirmed that no date was present on Resident 16 ' s nasal cannula tubing and that nebulizer equipment and CPAP mask was not properly stored in a bag, when not in use.</p> <p>Review of the clinical record indicated Resident R46 was admitted to the facility on [DATE].</p> <p>Review of Resident R46's MDS dated [DATE], indicated diagnoses of shortness of breath, COPD, and respiratory failure (inadequate gas exchange by the respiratory system). Section O0100, Oxygen therapy was marked.</p> <p>Review of a physician's active orders dated 9/13/24, indicated to administer oxygen via nasal cannula continuously at 4 liters per minute.</p> <p>During an observation on 9/30/24, at 12:22 p.m. Resident R46 was laying in her bed receiving 4 liters per minute of oxygen via nasal cannula. No date was present on the oxygen nasal cannula.</p> <p>During an interview on 9/30/24, at 12:27 p.m. RN Employee E1 confirmed that no date was present on R46's nasal cannula tubing.</p> <p>During an interview on 9/30/24, at 2:45 p.m. the Director of Nursing confirmed that the facility failed to provide appropriate respiratory care for two of two residents (Resident R16 and R46).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.</p> <p>28 Pa. Code: 211.12(d)(3) Nursing services.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395773	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/16/2024
NAME OF PROVIDER OR SUPPLIER  East End Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  745 North Highland Avenue Pittsburgh, PA 15206	
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49469</p> <p>Based on review of facility policy, observations and staff interview it was determined that the facility failed to label/date opened medications on one of two medication carts (3 South medication cart) and failed to properly store medical supplies and biologicals in one of two medication carts (3 South medication cart) and failed to secure treatment medications and supplies in one of two treatment carts. (3rd floor treatment cart).</p> <p>Findings include:</p> <p>A review of the facility policy General Dose Preparation and Medication Administration dated [DATE], indicates facility staff should enter the date opened on the label of medications with shortened expiration dates (e.g., insulins, irrigation solutions, etc.).</p> <p>A review of the facility policy Storage and Expiration Dating of Medications dated [DATE], indicated facility should ensure that food is not to be stored in the refrigerator, freezer, or general storage areas where medications and biologicals are stored. Facility should ensure that medications and biologicals have an expired date on the label. Once any medication or biological package is opened, facility should follow manufacture/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (i.e., vial, bottle, inhaler).</p> <p>During an observation on [DATE], at 9:25 a.m. the three south medication cart top drawer contained one vial of Lispro insulin with no date opened, one medicine cup containing one beige pill with PEN in black lettering. The bottom drawer of the medication cart contained five half individual peanut butter and jelly sandwiches.</p> <p>During an interview on [DATE], at 9:33 a.m. Registered Nurse (RN) Employee E1 stated I have no clue who put it in there, it was in there this morning when I took possession of the cart, same with the peanut butter and jelly sandwiches and confirmed that the facility failed to label/date opened medications on one of two medication carts (3 South medication cart) and failed to properly store medical supplies and biologicals in one of two medication carts (3 South medication cart).</p> <p>During an observation of the Third-floor nursing unit on [DATE], at 12:20 p.m. the treatment cart was observed unlocked positioned in front of the nursing station, right in front of the elevator no staff was observed near the treatment cart.</p> <p>During an interview on [DATE], at 12:22 p.m. Licensed Practical Nurse (LPN) Employee E2, confirmed that the third-floor treatment cart was unlocked, and the facility failed to secure treatment medications and supplies in one of two treatment carts. (3rd floor treatment cart).</p> <p>28 Pa. Code:211.12(d)(1)(2)(3)(5) Nursing services.</p> <p>28 Pa. Code: 211.9(a)(1)(h)(k)(l)(1) Pharmacy services.</p> <p>(continued on next page)</p>		

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F 0761  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	28 Pa. Code: 211.10(c) Resident care policies.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075</b></p> <p>Based on review of facility policy, observation, clinical record review, and staff interviews, it was determined that the facility failed to provide a safe and sanitary environment to help prevent the potential for cross contamination for two of two laundry room observations, failed to provide PPE (Personal Protective Equipment) signage which created the potential for cross-contamination and the spread of diseases and infections for one of two residents (Resident R51), failed to prevent cross contamination during a dressing change for one of three residents (Resident R16) and failed to prevent cross contamination during a medication pass for one of two residents (Residents R52).</p> <p>Findings include:</p> <p>Review of the facility policy Linen Management Policy dated 4/1/24, indicated linen will be handled, transported, and processed in a manner which reduces risk of contamination or cross contamination. The facility will handle all used linen as potentially contaminated and use stand precautions when handling, sorting, or rinsing. All linen will be handled, stored, processed, and transported in a safe and sanitary manner. Processes:</p> <p>All linen</p> <ul style="list-style-type: none"> <li>- Clean and contaminated linens will not be stored in the same location.</li> </ul> <p>Laundry Carts</p> <ul style="list-style-type: none"> <li>- Clean linen carts will be covered unless being restocked or linens are being retrieve.</li> </ul> <p>Soiled (dirty) and Contaminated Linen</p> <ul style="list-style-type: none"> <li>- When handling soiled linen, laundry personnel will wear gloves and gowns. If splashing is likely, mask and eye protection will also be worn.</li> </ul> <p>Review of the facility policy Infection Prevention and Control Program Policy dated 4/1/24, indicated the facility will maintain an organized, effective facility-wide program designed to systematically prevent, identify, control, and reduce the risk of acquiring and transmitting infections among employees, volunteers, visitors, and contracted healthcare workers; to conduct surveillance of communicable disease and infectious outbreaks; and to monitor employee health. The Infection Preventionist ' s responsibilities for infection prevention and control include to assures compliance with state-federal regulatory standards as they pertain to infection prevention and control matters within the facility.</p> <p>Review of the facility policy Clean Dressing Change Policy dated 4/1/24, indicates where sterile technique is not ordered or indicated, wounds will be dressed using clean technique which avoids direct contamination of material and supplies.</p> <p>Review of the facility policy General Dose Preparation and Medication Administration dated 4/1/24, indicates medications should not come in contact with any surface except for the medication cup.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a tour of the laundry room on 10/1/24, at 9:55 a.m. no protective gowns were observed to use while sorting and washing dirty laundry.</p> <p>During an interview on 10/1/24, at 10:00 a.m. Laundry personnel Employee E7 stated, We don't wear gowns, we just use gloves while washing the laundry.</p> <p>During an observation on 10/3/24, at 2:00 p.m. two clean linen carts were being stored in the hallway across from the laundry area and failed to have the clean linens covered exposing it to dust and contaminates in the hallway causing potential for cross contamination.</p> <p>During an interview on 10/1/24, at 2:03 p.m. Laundry personnel Employee E7 stated, The linen cart should be covered.</p> <p>During an observation on 10/3/24, at 2:05 p.m. a clean linen cart that had residents clean laundry hanging had a used isolation gown laying on top of the rack.</p> <p>During an interview on 10/1/24, at 2:07 p.m. Laundry personnel Employee E8 stated, I just used that to wash a load of laundry. I'm glad you said something because I should have thrown it away.</p> <p>During an observation on 10/3/24, at 2:10 p.m. approximately ten bags of linen were under the clean table that employees fold linen on. When asked what those bags are, Laundry personnel Employee E7 stated, They are dirty clothes that need washed.</p> <p>During an observation on 10/3/24, at 2:13 p.m. two bins were sitting beside each other by the washer. When asked what was in the bins, Laundry personnel Employee E8 stated, One is dirty rags, and one is clean rags.</p> <p>During an interview on 10/3/24, at 2:15 p.m. Director of Laundry Employee E6 confirmed that the facility failed to provide a safe and sanitary environment to help prevent the potential for cross contamination for two of two laundry room observations.</p> <p>Review of Admission record indicated Resident R51 admitted to the facility on [DATE].</p> <p>Review of Resident R51's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/3/24, indicated the diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking), and hypothyroidism (underactive thyroid).</p> <p>Review of Resident R51's clinical record on 9/30/24, at 11:00 a.m. indicated Resident R51 was ordered Enhanced Barrier Precautions (EBP, a special isolation precaution that requires gloves and gowns during certain resident care).</p> <p>During an observation on 9/30/24, at 11:15 a.m. the facility failed to provide signage of EBP on resident's door to ensure that employees, visitors, and family members are utilizing PPE, when indicated.</p> <p>During an interview on 10/1/24, at 12:46 Infection Preventionist Employee E2 stated, The unit managers and me are the ones responsible for implementing and hanging up the EBP signage.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/1/24, at 2:30 p.m. Director of Nursing confirmed that the facility failed to provide PPE signage which created the potential for the cross-contamination and the spread of diseases and infections on one of two residents (Resident R51).</p> <p>Review of Resident R52 medical record indicated an admitted [DATE], with the diagnosis of fibromyalgia (causes widespread musculoskeletal pain), diabetes (high sugar in the blood), and anxiety.</p> <p>Review of Resident R52's Minimum Data Set (MDS) dated [DATE], indicates diagnosis as current.</p> <p>Review of Resident R52's physician orders dated 8/30/24, indicated resident to receive:</p> <p>- Acetaminophen (OTC) tablet 500mg, two tablets twice a day.</p> <p>During an observation on 10/1/24 at 9:08 a.m. Registered Nurse (RN) Employee E1 donned a pair of gloves prior to Resident R52's medication pass. RN Employee E1 pulled the medications from the blister packs and placed into the medication cup. RN Employee E1 dispensed medication from stock Acetaminophen bottle into the lid of container. RN Employee E1 then plucked one pill out of lid and placed back into bottle, then using the lid placed the two pills into the medication cup with the other medications.</p> <p>During an interview on 10/1/24, at 9:22 a.m. RN Employee E1 confirmed that she did not perform hand hygiene and apply a new pair of gloves prior to handling the medications and the facility failed to prevent cross contamination during a medication pass for one of two residents (Resident R52).</p> <p>Review of Resident R16's medical record indicated an admitted [DATE], with the diagnosis of hypertension (high blood pressure), diabetes (high sugar in the blood), and hyperlipidemia (high fats in the blood).</p> <p>Review of Resident R16's Minimum Data Set (MDS) dated [DATE] indicates diagnosis as current.</p> <p>Review of Resident R16's physician orders dated 9/23/24, indicated to cleanse sacrum with wound cleanser apply Medihoney and cover with dry dressing daily.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 10/2/24, at 10:05 a.m. Licensed Practical Nurse (LPN) Employee E4, LPN Employee E4 entered Resident R16's room to complete dressing change. LPN Employee E4 cleansed bedside table, and placed trashcan next to table, washed her hands, confirmed treatment order, placed Medihoney in medicine cup, gathered the rest of supplies one packet of gauze sponges, one dry cover dressing and one tongue depressor. LPN Employee E4 then donned her Personal Protective Equipment (PPE) placed her treatment supplies onto the left side of bedside table. She returned to sink washed her hands, donned new gloves, and placed two brown paper towels from dispenser by sink onto the table. She then went over to resident R16's dresser and removed a bottle of wound cleanser spray and placed it onto table. LPN Employee E4 positioned Resident R16 to the left and unfastened her brief. After cleansing the wound, LPN Employee E4 released Resident R16's skin allowing the clean wound to touch the inside of the brief. LPN Employee E4 left resident to complete hand hygiene, donned new gloves, and returned to resident, positioned to left side applied the Medihoney and released Resident R16's skin allowing the Medi honey to touch the inside of the brief, she then completed hand hygiene, donned new gloves, returned to Resident R16, and placed her to the left side applied dry dressing and fastened brief. LPN Employee E4 returned to sink completed hand hygiene, donned new gloves, repositioned resident in bed, put the bed in a comfortable position for resident and placed call bell within reach. LPN Employee E4 removed PPE including gloves, picked up the bottle of wound cleanser with bare hands and placed back into Resident R16's dresser drawer. She then returned to the sink and washed her hands. LPN Employee E4 then left room to retrieve a red bag and returned to room, applied gloves put trash into red bag, washed her hands and put bedside table back into Resident R16's reach.</p> <p>During an interview completed on 10/2/24, at 10:39 a.m. LPN Employee E4 confirmed not establishing a clean barrier field prior to dressing change, not placing a clean barrier field under the resident, allowing Resident R16's wound area to touch the brief, and placing the wound cleanser back into Resident R16's top dresser drawer. LPN Employee E4 stated wound cleanser is always kept in room. LPN Employee E4 confirmed that the facility failed to prevent cross contamination during a dressing change for one of three residents (Resident R16).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 211.10(d) Resident care policies.</p> <p>28 Pa. Code: 201.18 (b) (1) (e) (1) Management.</p> <p>28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.</p>		