STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395883	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burgh Care Center	909 West Street Pittsburgh, PA 15221

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 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785 Based on review of facility policy, job description, clinical record review, personnel records, resident and staff interviews, it was determined that the facility failed to provide care and services to meet the accepted standards of practice for one of four residents reviewed which resulted in actual harm requiring a transfer to the hospital (Resident R1). Findings include: The facility Skin breakdown policy last reviewed 9/18/24, indicated that the nurse staff and practitioner will assess and document an individual's significant risk factors. The physician will help identify factors contributing to skin breakdown. The physician will help identify medical interventions related to wound management, for example treating a soft tissue infection, removing necrotic tissue, and managing pain. The facility LPN Supervisor job description last reviewed 9/18/24, indicated to administer professional services such as applying and changing dressings. Supervision in this position must be in accordance with current federal, state, and local standards, guidelines and regulations. Review of Resident R1's admission record indicated she was originally admitted on [DATE]. Review of Resident R1's MDS assessment (MDS: Minimum Data Set assessment-a periodic assessment of resident care needs) dated 3/25/25, indicated she had diagnoses that included spinal stenosis (compression of nerves in the spinal cord causing pain and discomfort), anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry), hypertension (a condition impacting blood circulation through the heart related to poor pressure), and hypothyroidism (decrease in production of thyroid hormone). Review of Resident R1's care plan dated 1/17/ 25, indicated Resident R1 had potential for skin impairment. Review of Resident R1's physician orders dated 2/17/25, indicated licensed nurse to perform skin head-to-toe checks and document. Physician orders on 4/18/25, indicated to administer Cephalexin (antibiotic) for infection. A physician order dated 4/20/25, indicated to cleanse area to upper back. The record did not indicate any physician orders to excise, debride or open any skin areas to Resident R1. (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 0658 Level of Harm - Actual harm Residents Affected - Few	Review of Resident R1's skin assessment on 4/17/25, indicated a new abscess measuring 4.5 cm x 4.0 cm x 0 cm. Review of Resident R1's clinical progress note dated 4/17/25, indicated Resident R1 alerted staff that she has abscess on her back, midline. 4.5 cm x 4 cm, redness noted and warm to touch. Some tenderness noted. Doctor notified. Verbal order obtained for antibiotic 500 mg four times a day for seven days, also vitals per shift. Resident R1 updated, verbalized understanding. Review of Resident R1's Nurse Practitioner note dated 4/18/25, indicated Resident R1 was seen for an abscess on her back. It was noticed yesterday, and she was started on antibiotic. She has had no fevers, other vitals stable per nursing, but Resident R1 reports the area is very tender. Nursing reportedly tried to drain the area earlier, unclear the procedure but concern for infection so patient was sent to Emergency Department. Review of Resident R1's discharge hospital records dated 4/19/25, indicated she was seen on 4/18/25 due to abscess. Facility documents submitted to the state dated 4/18/25, indicated that Resident R1 reported to 3-11 supervisor and her attending doctor that the daylight LPN excised a cyst to left midline scapula. Resident R1 stated that she felt that the LPN used some type of 'tool' to open her skin. Licensed Practical Nurse (LPN) Employee E1 provided statement via phone dated 4/18/25. He stated that Resident R1 requested if he could do something about the cyst on her back. He said he could. He stated he grabbed a couple of things such as alcohol wipes, 4 x 4 gauze. He then went to Resident R1's room, applied Lidocaine gel (pain reducing ointment) to try and numb the area before he squeezed the cyst. He stated he had tweezers but did not use them. Assistant Director of Nursing (ADON) Employee E2 provided statement dated 4/18/25. She stated she was getting report on the beginning of her shift. Licensed Practical Nurse (LPN) Employee E1 stated that Resident R1's cyst was coming to a head and he wanted to pop it. She told him wound team would look at it. Licensed Practical Nurse (LPN) Employee E1 later told her he took care of Resident R1's cyst and covered it with a bandage. Review of Licensed Practical Nurse (LPN) Employee E1's personnel record indicated he was hired on 3/24/25 and signed the LPN job description. His employment ended 4/23/25. During an interview on 4/28/25, at 9:24 a.m. Resident R1 stated the following: my back. Yes, a nurse operated on me. I think it was a male nurse Licensed Practical Nurse (LPN) Employee E1. He got instruments from a cart. The instruments were not sanitized. He used lidocaine cream to numb it. He lanced the cyst. When he cut it, it hurt. From one to ten, the pain was a ten. He did not use alcohol or anything on his instruments. Later on that night, a supervisor asked me to look at my back. And I had to go to the hospital. They had to cut it open at the hospital. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	During a phone interview on 4/28/25, at 11:15 a.m. Licensed Practical Nurse (LPN) Employee E1 stated the following: As I recall, yes it was on 4/18/25. Resident R1 told me she had uncomfortable cyst on back. There was a tiny white head on medial area. I had set of tweezers. They were blunt. I took two 4x4 gauze. She was already on an antibiotic. I applied some pressure, and there was a little bit of blood and pus. She said it comes back every 12 months or so. I did not have any tools that could have lanced it. I had alcohol. I do not carry a scalpel. It was larger than the little bit of pus came out. I was working the floor by myself that day. She had a lidocaine cream, and she asked me to apply it to her back. That belongs to the Resident R1. I cleaned the area with alcohol swab and put gauze over it. She said she felt better. When asked if there was an order to squeeze it or to perform any procedure, LPN Employee E1 stated no. During an interview on 4/28/25, at 11:57 a.m. Assistant Director of Nursing (ADON) Employee E2 stated: I did not see him with any tools. When I came on that Friday, I was getting report with him and another nurse. Resident R1 had abscess on her back. He mentioned he could squeeze it. I told him to leave that alone. That is not what we do. We do wound rounds, and I was going to mention it to the wound nurse. An LPN is not supposed to Lance anything. Never. There was no order. I told him not to do anything to that cite! During an interview on 4/28/25, at 12:10 p.m. Registered Nurse (RN) Employee E3 was asked about lancing resident if they have a abscess and she stated: never. Never. A nurse must contact a doctor. During an interview on 4/28/25, at 12:39 p.m. Registered Nurse (RN) Supervisor Employee E4 stated the following: I was doing a smoke break that evening. Resident R1's doctor who does rounds on the evenings was here. Resident R1 spoke to her doctor, and she brought it to my attention. I then spoke to the DON and NHA and made them aware of the concern. You do not lance as an RN or LPN. That is outside the scope of practice. During an interview on 4/28/25, at 3:25 p.m. information disseminated to the Nursing Home Administrator (NHA) and Director of Nursing) that the facility failed to provide care and services to meet the accepted standards of practice for Resident R1 which resulted in actual harm requiring a transfer to the hospital. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.