

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395883	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Burgh Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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, facility documents, clinical record review, and resident and staff interviews, it was determined that the facility failed to create an environment free of accidents when the facility allowed a resident (Resident R1) to leave the facility unsupervised when the outside temperature was approximately 95 degrees, and the resident developed heat stroke (a serious health condition when the body temperature rises to 104 degrees or more due to exposure to high temperatures) while out of the facility. This created an immediate jeopardy situation for one of 37 residents who was approved for a LOA- (leave of absence- when the facility allows a resident to leave the facility for a short period of time) Findings include: Review of the facility admission Agreement indicated a resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely. Review of Resident R1's clinical record indicated that he was admitted to the facility on [DATE]. Review of Resident R1's clinical record revealed a care plan intervention dated 12/13/24, to allow resident to go out on a LOA. Review of Resident R1's clinical record revealed an order written by a Nurse Practitioner on 3/12/26, for independent LOA (leave of absence- when the facility allows a resident to leave the facility for a short period of time) - must return by 11 p.m. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/8/26, indicated diagnoses of amputation (right leg- above the knee), high blood pressure, and Peripheral Vascular Disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Section C0500 Brief Interview of Mental status indicated score of 15, indicative of being cognitively intact. Review of facility document Resident Leave of Absence revealed on 7/3/26, at 9:38 a.m. Resident R1 signed himself out of the facility. Destination was listed as shopping and Escort Name was listed as self. Review of Resident R1's clinical record revealed a progress note dated 7/3/26, at 2:46 p.m. that stated, Out of the building. Review of Resident R1's clinical record revealed a progress note dated 7/3/26, at 5:27 p.m. indicating the following: Nurse from [hospital] called supervisor phone. She informed me that resident is currently a patient in their ER (emergency room). Evidently resident was found by the police in his electric wheelchair. Wheelchair had stopped running and the tires had 'melted into the pavement'. On arrival resident's temperature was 106, he is being treated for 'heat exhaustion'. Review of Resident R1's clinical record revealed a progress note dated 7/3/26, at 7:31 p.m. indicating the following ER called back. Resident being admitted to their facility with diagnosis of heat stroke. His wheelchair is at the police station. During an interview on 7/7/26, at 9:12 a.m. Nurse Aide (NA) Employee E1 revealed she was aware of Resident R1's incident with his wheelchair and heat stroke on 7/3/26. NA Employee E1 stated, they used to have a green sheet that the facility utilized for when a resident would go out on a LOA. The resident would go to their nurse for the 'green sheet', which acted as sort of a 'hall pass'. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	staff must confirm a current physician order and that applicable assessment (e.g. elopement (when a resident leaves a supervised area without permission), falls, BIMS (Brief Interview for Mental Status- a brief test to assess mental ability) support the LOA, with or without supervision, before any resident leaves the building. Policy adds a weather/environmental limit; unsupervised leave may be restricted or suspended facility-wide during extreme heat, extreme cold, or other hazardous conditions. Unsupervised LOA suspended facility-wide until individualized review of every resident with an existing LOA order is complete; only supervised LOA (responsible party physically present) permitted until then. Serious Injury/Harm Investigation opened 7/4/26 upon DON (Director of Nursing) notification: staff and resident interviews, reconstructed timeline of departure and return, and review of order/sign-out documentation/assessments in place at the time. Resident interview with [Resident R1] conducted on 7/6/26 upon readmission [from hospital stay], documented in the Interview Summary- resident confirming the timeline and circumstances of the incident. Findings and corrective actions documented in formal QAPI (Quality Assurance and Performance Improvement) report; root cause identified as weather conditions not factored into the leave decision, no expected duration/return time documented, and no confirmed way to reach the resident during leave. Resident R1 reassessed and included in the facility's current LOA review. Need for Immediate Action Interim LOA/Out on Pass Policy completed and in effect facility-wide as of today, 7/7/26. Facility-wide suspension of unsupervised LOA completed and in effect as of today, 7/7/26, until each resident with an existing LOA order is individually reviewed against the new policy. Initial Audit Sweep of all current residents with a LOA order or expressed desire for one to be completed by tomorrow, 7/8/26, confirming physician order, applicable assessments, and appropriate supervision level for each resident before any LOA (supervised or unsupervised) resumes; care plans will be updated accordingly once this review is complete. LOA Request Forms reimplemented facility-wide as of today, 7/7/26, documenting the facility's decision and any resident-specific instructions for every LOA going forward. Sign-Out/Sign-In Log implemented facility-wide as of today, 7/7/26, capturing destination, responsible party, phone number, supervision status, and staff signature for every resident leaving the building. Staff education on the revised policy and forms to be completed by tomorrow, 7/8/26, facility-wide, with signed staff acknowledgement on file. Ongoing 12-week audit tool completed and in place as of today, 7/7/26, covering new admissions, residents with LOA orders, and any resident with a change in condition or significant event, with findings reported to QAPI. Residents and responsible parties will be educated on the new interim policy through phone calls, one-to-one conversations, and resident council meetings. During an interview on 7/8/26, at 12:06 p.m. Housekeeping Employee E5 confirmed that he was made aware of the incident involving Resident R1 and stated: It was too hot out that day. Shouldn't go out in that heat. During an interview on 7/8/26, at 12:07 p.m. Maintenance Employee E6 also confirmed awareness of the incident and stated: I feel they shouldn't be out unsupervised regardless. They are here for a reason, and we need to keep them safe. During an interview on 7/8/26, at 12:22 p.m. Laundry Employee E7 stated They [residents] shouldn't be out [unsupervised] anyway. What if they have a motorized wheelchair and the battery dies or something? During an interview on 7/8/26, at 12:40 p.m. Driver Employee E8 stated Ain't nobody going nowhere without anyone with them. Review of facility documents, and clinical documentation on 7/8/26 revealed the following: LOA policy has been reviewed and revised to include that residents require a nursing check prior to departure, verification of physician order, weather limits, and supervision required Facility investigation completed QAPI completed Facility-wide suspension of unsupervised LOA was implemented All residents who desire LOA (37 out of 74) have appropriate LOA orders as deemed appropriate, and all orders for LOA include to have supervision, (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and are care planned accordinglyLOA form is now being used, which is issued, and completed by the nurse. This is the [NAME] Sheet that staff had used and liked previously.New logbook at front desk files the LOA form, and residents and responsible party sign out with the receptionist in this book.Staff education completed on 100 out of 106 employees. This was verified by 29 employee interviews27 out of 37 families of residents who have orders for LOA have received education on new policy, and education will be ongoing.22 of 37 residents with LOA orders were educated on new policy, and education will be ongoing. The Immediate Jeopardy was lifted on 7/8/26, at 4:00 p.m. when the action plan implementation was verified. During an observation on 7/9/26, at 9:10 a.m. Driver Employee E8 was in the lobby when someone came down with a resident in a wheelchair to go to an appointment. Driver Employee E8 was heard stating the following: I'm not taking anyone anywhere without a LOA form. I don't mess with safety when it comes to the residents. During an interview on 7/9/26, at 10:40 a.m. RN Employee E4 confirmed that he was assigned to take care of Resident R1 on the day of the incident and stated I didn't know he was out that day until I went to give him his meds [medication] in the afternoon. I'm glad we went back to the old process. During an interview on 7/9/26, at 11:13 a.m. the Operations Manager Employee E9 confirmed that the facility failed to create an environment free of accidents when the facility allowed Resident R1 to leave the facility on a LOA unsupervised when the outside temperature was approximately 95 degrees, and the resident developed heat stroke, resulting in immediate jeopardy for one of 37 residents who was approved for a LOA. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(e)(1) Management.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of Resident Council meeting minutes, and resident and staff interviews, it was determined the facility failed to consider the views of a resident and act promptly on concerns and recommendations concerning issues of resident care and life in the facility for two of two months (May, and June 2026). Findings include: Review of facility admission Agreement indicated that the resident has a right to organize and participate in resident groups in the facility. The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. Review of facility provided Resident Council Meeting Minutes dated 5/26/26, indicated: Residents reported concerns regarding a washer that is in need of repair. Staff advised that the issue would be reported for maintenance and that repairs would be scheduled as soon as possible. Review of facility provided Resident Council Meeting Minutes dated 6/19/26, indicated: Residents reported that the washing machine continues to require repair. Management acknowledged the concern and advised that maintenance would be notified to address this issue. During an interview on 7/7/26, at 10:01 a.m. Maintenance Director (MD) Employee E10 stated that there is a washing machine on the Fourth Floor that residents can use if they desire to wash their own clothes, and that it has been broken. MD Employee E10 stated that he just brought up the washing machine that was in Occupational Therapy onto the Fourth Floor so that residents could use it on 7/3/26. During an interview on 7/7/26, at 11:21 a.m. Resident R1 stated that he prefers to do his own laundry so that it won't get lost, and that he would normally use the washing machine on the Fourth Floor, however it has been broken since May. Therefore he left the facility on 7/3/26, around 9:30 in the morning to go to the laundromat. During an interview on 7/8/26, at 4:07 p.m. Operations Manager Employee E9 confirmed that the facility failed to consider the views of a resident and act promptly on concerns and recommendations concerning issues of resident care and life in the facility for two of two months (May, and June 2026). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(e)(4) Management. 28 Pa. Code: 201.29(a) Resident rights.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review, and staff interviews, it was determined that the facility failed to conduct ongoing clinical assessments to make certain that residents were provided appropriate treatment and care for two of two residents reviewed (Residents R2, and R3). Findings include: Review of facility policy Elopements and Wandering Residents dated 2/11/26, indicated that residents will be assessed for risk of elopement (when a resident leaves the facility without permission, and/or supervision) and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. Review of facility policy Fall Prevention Program dated 2/11/26, indicated that upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. Complete a fall risk assessment every 90 days and as indicated when the resident's condition changes. Review of the clinical 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 5/17/26, indicated diagnoses of high blood pressure, malnutrition (lack of sufficient nutrients in the body), and heart failure (a progressive heart disease that affects pumping action of the heart muscles). Review of Resident R2's clinical record revealed that the last Elopement Risk Evaluation was completed on 3/27/25, when the resident was admitted to the facility. Review of Resident R2's clinical record revealed that the last Fall Risk Evaluation was completed on 11/24/25. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and muscle weakness. Review of Resident R3's clinical record revealed that the last Elopement Risk Evaluation was completed on 5/14/25, when the resident was admitted to the facility. Review of Resident R3's clinical record revealed that the last Fall Risk Evaluation was completed on 5/14/25, when the resident was admitted to the facility. During a telephonic interview on 7/8/26, at 10:20 a.m. the Director of Nursing (DON) stated that the facility has only been conducting Elopement Risk Evaluations, and Fall Risk Evaluations upon admission, and readmission to the facility after a hospitalization, and has failed to conduct ongoing clinical assessments to make certain that residents were provided appropriate treatment and care for two of two residents reviewed. 28 Pa. Code: 201.14(a) Responsibility of licensee. 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.		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job descriptions, clinical records and staff interviews, it was determined that the Former Nursing Home Administrator (FNHA) and the Director of Nursing (DON) failed to effectively manage the facility when the facility allowed a resident (Resident R1) to leave the facility unsupervised when the outside temperature was approximately 95 degrees, and the resident developed heat stroke (a serious health condition when the body temperature rises to 104 degrees or more due to exposure to high temperatures) while out of the facility. This created an immediate jeopardy situation for 37 residents who were approved for a leave of absence (LOA) .Findings include: The signed job description for the Former Nursing Home Administrator Employee E13, dated 5/4/26, specified the primary purpose of the job position is to manage the Facility in accordance with current applicable federal, state, and local standards, guidelines, and regulations that govern long-term care facilities To follow all facility policies and apply them uniformly to all employees. The ensure the highest degree of quality care is provided to our residents at all times. The signed job description for the Director of Nursing, dated 5/18/26, specified the purpose of the job is to plan, organize, develop and direct the overall operation of the Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern the facility, and as may be directed by the Administrator and the Medical Director, to ensure that the highest degree of quality care is maintained at all times. During an interview on 7/7/26, at 10:34 a.m. the Nursing Home Administrator (NHA) stated that her first day working at the facility was 7/6/26, and that she had been called the day after the incident to fill in as interim NHA, as the Former NHA Employee E13's employment was unexpectedly terminated on 7/3/26. Based on findings identified in this report, the facility failed to create a safe environment free of accidents when the facility allowed a resident (Resident R1) to leave the facility unsupervised when the outside temperature was approximately 95 degrees, and the resident developed heat stroke, which created an immediate jeopardy situation for 37 residents who were approved for LOA in Immediate Jeopardy. The Former NHA Employee E13, and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 7/9/26, at 11:13 a.m. Operations Manager Employee E9 was notified that the Former NHA Employee E13, and the DON failed to effectively manage the facility by failing to create a safe environment free of accidents when the facility allowed a resident (Resident R1) to leave the facility unsupervised when the outside temperature was approximately 95 degrees, and the resident developed heat stroke, which created an immediate jeopardy situation for 37 residents who were approved for LOA in Immediate Jeopardy. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(3)(e)(1) Management.		