

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 04/05/2025
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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>35785</p> <p>Based on facility policy review, observations, and resident and staff interviews, it was determined that the facility failed to maintain a safe, clean, and home-like environment for one of seven sampled residents (Resident R71).</p> <p>Findings include:</p> <p>The facility Homelike environment policy last reviewed 9/18/24, indicated that residents are provided with a safe, clean, comfortable and homelike environment with characteristics that include a sanitary and orderly environment.</p> <p>During observations on 4/3/25, at 2:27 p.m. observations of Resident R71 room was observed with chocolate milk on the floor, clear fluid on floor, cups, clothes on floor and one jacket on floor.</p> <p>During observations on 4/3/25, at 2:53 p.m. observations of Resident R71 room was observed with chocolate milk on the floor, clear fluid on floor, cups, clothes on floor and one jacket on floor. Observations done with Nurse aide Employee E3</p> <p>During an interview on 4/3/25, at 2:54 p.m. Nurse Aide Employee E3 stated: we will have housekeeping clean this.</p> <p>During observations on 4/5/25, at 9:32 a.m. observations of Resident R71 room found with white sheet on the floor, a pink blanket on the floor, botches of brown substance on floor, odor of urine, and white cup lid on the floor.</p> <p>During an interview on 4/5/25, at 10:04 a.m. information disseminated to the Nursing Home Administrator (NHA) that the facility failed to maintain a safe, clean, and home-like environment for Resident R71 as required.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(3) Management</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469</p> <p>Based on review of facility policy, facility documents, clinical records, resident interview, and staff interviews, it was determined that the facility failed to provide appropriate goods and services to prevent falls, resulting in neglect for one of five residents (Resident R32), which resulted in actual harm requiring a transfer to the hospital for evaluation of head trauma that resulted in an acute minimally depressed right orbital floor fracture for one of five residents (Resident R32).</p> <p>Findings include:</p> <p>Review of facility policy Protection from Abuse last reviewed 9/18/24, indicated that each resident has the right to be free from abuse, corporal punishment, involuntary seclusion, neglect and misappropriation of property. The facility shall have processes in place to include screening, reporting and response to allegations of potential or actual abuse and neglect. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect.</p> <p>Review of the facility policy Bed Safety and Bed Rails last reviewed 9/18/24, indicated consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment.</p> <p>Review of facility's current Nurse Aide (NA) job description indicated the primary purpose of your (NA) job is to provide each of your assigned residents with routine daily nursing care and services in accordance with the residents assessment and care plans as may be directed by supervisor in accordance with the requirements of the policies and procedures of this facility in accordance with federal, state, and local standards governing the facility.</p> <p>Review of the admission record indicated R32 was admitted to the facility on [DATE].</p> <p>Review of Resident R32's Minimum Data Set (MDS- a periodic assessment of care needs) dated 3/19/25, indicated diagnoses of respiratory failure (lungs have trouble loading your blood with oxygen), heart failure (heart doesn't pump the way it should), and diabetes (high sugar in the blood). Section GG Roll left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed indicated resident is Partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort).</p> <p>Review of Resident R32's physician order dated 3/24/25, indicated bilateral side rails.</p> <p>Review of Resident R32's care plan on 3/31/25, at 12:38 p.m. failed to include the use of side rails.</p> <p>Review of Resident R32's progress note dated 3/31/25, at 06:43 a.m. indicated resident fell out of bed while having care done aide with her resident has a big knot on right eye 911 called and sent to hospital at 645 am.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R32's progress note dated 3/31/25, at 6:53 a.m. indicated resident fell out of bed during hygiene. Nurse Aid (NA) reports Resident went limp during care and rolled out of bed onto floor. Bed in high position prior to fall. Writer discovered Resident on floor next to bed moaning, complained of (c/o) left sided pain, pointed to hip. No internal or external rotation to either extremity noted. Redness noted to right elbow, purple hematoma noted to rt eye. Resident had difficulty remaining awake and alert during assessment, staff at bedside throughout entire event. MD notified; message left for Resident's daughter. Resident transferred to hospital for emergency evaluation. VS 96.7 82 20 170/83 pulse ox 99% on ordered O2.</p> <p>Review of Resident R32's progress note dated 4/1/25, at 1:50 a.m. indicated resident returned from hospital. No new orders at this time. Resident assisted into bed, call bell within reach. Bed in lowest position.</p> <p>During an interview and observation on 4/2/25, at 9:31 a.m. Resident R32 was in bed, no side rails observed to bed. Residents R32's eye was red, with bruising noted around her eye as well as her right neck. Upon asking resident R32 what happened she replied I have fallen out of bed, I have been asking for rails, I would be able to pull myself over and hold onto it. Upon further query Resident R32 stated they rearranged my furniture so there was nothing to hold onto. She rolled me away from her towards the window, I jerked like I was going to fall. They use one aid and roll me both ways I was dropped the bed was up. The residents bed side stand was noted to the left side of her bed against the walls as well as a stand on wheels closer to her bed and in reach of her left hand. Further interview completed Resident R32 stated I am waiting for my care as I have an appt at 12:00. This was not the first time rolling out I have fallen, no new intervention were put in place for me, I still don't have rails, they are rising me up for their backs.</p> <p>During an interview completed on 4/2/25 at 9:50 a.m. RN Employee E2 confirmed no side rails were on Resident R32's bed.</p> <p>During an interview completed on 4/3/25, at 10:00 a.m. upon asking Licensed Practical Nurse (LPN) Employee E11 concerning side rail placement she replied if I had someone that was ordered bed rails I would expect to see them as soon as possible, it has to be an order.</p> <p>During an observation and interview completed on 4/3/25, at 10:05 a.m. Resident had complaints of feeling dizzy, LPN Employee E11 stated that Resident R32 was not right at all and she is going to be sent out for a change in condition.</p> <p>During an interview completed on 4/3/25, at 11:58 a.m. LPN Employee E11 confirmed that Resident R32 was sent to the hospital for a change in her condition and stated that when the medics arrived for transfer resident was more alert and didn ' t want to go, but she did just have a head injury, you never know I take that very serious.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephonic interview completed on 4/3/25, at 10:54 a.m. upon asking Nurse Aid (NA) Employee E16 is she could recall the events that took place concerning Resident R32's fall from bed she replied, I do, I was changing her everything need to be changed. I had to position her on her side and there was no side rail she let go of her nightstand and [NAME]. She did not have rails she was holding on one the nightstand and her [NAME]. The [NAME] had wheels her nightstand was stationary one hand was on the [NAME] and one was one her nightstand. I just pulled her over and put her on her left side. I pull the sheet toward me and it helps the resident start to turn I turned her away from me. I did not witness her hitting her head because I was at the foot of the bed putting the bottom sheet on. We were having a conversation, I had to wake her up to complete care, she did not go limp she just got quite and then I heard a thump. I went out to get the nurse right away. I helped the medics making her more comfortable, she had no complaints of pain, she makes her needs know, she lets you know.</p> <p>During an interview completed on 4/3/25, at 11:39 a.m. upon asking Occupational Therapist (OT) Rehab director Employee E17 which way are resident should be turned in bed, she replied you are to roll them toward you. Upon asking Employee E 17 concerning side rails for Resident R32 she replied Ideally as soon as you get an order you should be able to put them on. It would be appropriate for a resident request. I don't remember ordering them or doing an assessment. The RN put them in (order) the order should have been placed when the assessment was completed. An RN can put them in and confirmed Resident R32 had an order for side rails.</p> <p>During a telephonic interview completed on 4/3/25, at 1:43 p.m. upon asking Registered Nurse (RN) Employee E12 about the process for side rails she replied I would expect them by the next morning, when I'm there no one from maintenance is there. We use an app to notify them, I do the assessment first, I can't always follow up, I did put in for Resident R32 and sent the request to maintenance.</p> <p>Review of Resident R32 ' s hospital records indicate on 4/3/25, at 2:08 p.m. a CT scan (imaging test that uses x-rays and a computer to create detailed images of bone) of the Maxillofacial (upper jaw bone part of facial and skull structure) or sinuses without contrast final result:</p> <ol style="list-style-type: none"> 1. Acute minimally depressed right orbital floor fracture. 2. No acute cervical spine osseous abnormality. <p>Orbital floor fracture</p> <p>Evident from CT head imaging on 3/31</p> <p>Oral and Maxillofacial surgery consulted</p> <p>Review of nursing progress note dated 4/4/25, at 7:58 a.m. indicated Resident R32 was admitted to hospital with the diagnosis of altered mental status, ground level fall, encephalopathy (disease, damage or malfunction of the brain), and weakness.</p> <p>During an interview completed on 4/5/25, at 8:45 a.m. upon asking Nurse Aide (NA) Employee E18 which way a resident should be turned in bed, she replied I would ask them, or toward me.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>During an interview completed on 4/5/25, at 8:48 a.m. upon asking Nurse Aide (NA) Employee E19 which way are resident should be turned in bed, she replied towards you.</p> <p>During an interview completed on 4/5/25, at 8:55 a.m. upon asking RN Employee E2 concerning side rail placement she replied it should only take a day, it's through maintenance.</p> <p>During an interview completed on 4/5/25, at 9:00 a.m. upon asking Nurse Aide (NA) Employee E21 which way are resident should be turned in bed, she replied towards me.</p> <p>During an interview completed on 4/4/25, at 3:19 p.m. the Director of Nursing confirmed that the facility failed to provide appropriate goods and services to prevent falls, resulting in neglect for one of five residents (Resident R32), which resulted in actual harm requiring a transfer to the hospital for evaluation of head trauma for one of five residents (Resident R32).</p> <p>28. Pa Code 201.18(b)(1)(e)(1) Management.</p> <p>28. Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</p> <p>Based on review of facility documents, facility policy, clinical records, and resident staff interviews, it was determined that the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents for one of five residents (Resident R34).</p> <p>Finding include:</p> <p>Review of facility policy Abuse: Protection from Abuse dated 9/18/24, indicated neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility must identify occurrences and patterns of potential mistreatment/abuse. Residents will be protected during the abuse investigation. Reporting and filing of accurate documents relative to incident must be completed, and regardless of how minor an accident or incident may be, it must be reported to the department supervisor as soon as such accident/incident is discovered or when such information is learned. An investigation is implemented and witness statements are obtained.</p> <p>Review of facility policy Abuse and Neglect Protocol dated 9/18/24, indicated staff will investigate abuse and neglect to clarify what happened and identify possible causes. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. The staff will monitor individuals who have been abused to address any issues regarding their medical condition, mood, and function.</p> <p>Review of Resident R34's clinical record revealed that Resident R34 was admitted to the facility on [DATE], with diagnoses of tracheostomy (tube inserted through the neck to assist breathing) status, repeated falls, and hip fracture.</p> <p>Review of Resident R34's Minimum Data Set (MDS- assessment of resident's care needs) dated 2/28/25, indicated the diagnoses were current. Section C0200 BIMS (Brief interview for mental status) revealed that Resident R34 scored 13 which indicated that Resident R34 was cognitively intact.</p> <p>During an interview on 3/31/25, at 10:08 a.m. Resident R34 stated I wait five to six hours to be changed, I have sores on my buttocks due to not being changed.</p> <p>During an interview on 3/31/25, at 10:31 a.m. the Nursing Home Administrator was notified of the allegation of neglect Resident R34 reported. The NHA stated I already reported and submitted the investigation for Resident R34's allegation of neglect.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R34's investigation on 3/31/25, revealed Resident R34 reported an allegation of neglect on 3/3/25, 18 days prior. Resident R34 reported not having her brief changed in a timely manner, staff come into her room and turn off the call light, and don't return for hours. A further review of the investigation failed to identify an alleged perpetrator, the facility failed to obtain witness statements from nursing staff, and the witness statements obtained from the DON and Medical Director were signed by the Nursing Home Administrator. The allegation was unsubstantiated and stated no perpetrator named. Resident's R34's bladder elimination report attached to the investigation revealed the resident's brief was only changed two to three times a day.</p> <p>During an interview on 4/3/25, at 9:54 a.m. Resident R34 stated, today at 6:00 a.m. I peed and no one ever changed my brief until 9:00 a.m. Resident R34 indicated the call light was on, and no one came. Resident R34 indicated the nurse aide does not want to her. Resident R34 expressed a fear of retaliation.</p> <p>During an interview on 4/3/25, at 10:40 a.m. the Nursing Home Administrator was notified of Resident R34's neglect allegation.</p> <p>During an interview on 4/4/25, at 11:22 a.m. the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents as required for one of five residents (Resident R34).</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785</p> <p>Based on review of facility policy, resident record, investigation documents and staff interview, it was determined that the facility failed to report an allegation of neglect failed to report an allegation of neglect for one of five sampled residents (Resident R70).</p> <p>Findings include:</p> <p>The facility Protection from abuse policy dated 6/2023, last reviewed 9/18/24, indicated that each resident has the right to be free from abuse. Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm, pain, or mental anguish. Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect refers to failure through inattentiveness, carelessness or omission. The reporting and filing of accurate documents relative to incidents of abuse and reporting to state agencies as required include the Department of Health, Department of Aging, and Area Agency on Aging as appropriate.</p> <p>Review of Resident R70's admission record indicated she was admitted on [DATE].</p> <p>Review of Resident R70's MDS assessment (MDS: Minimum Data Set assessment-a periodic assessment of resident care needs) dated 3/3/25, indicated she had diagnoses that included chronic obstructive pulmonary disease (COPD: a disease characterized by persistent respiratory symptoms involving breathlessness, coughing, and obstructed airflow to the lungs), history of alcohol abuse, diabetes (metabolic disorder impacting organ function related to glucose levels in the human body) and hypertension (a condition impacting blood circulation through the heart related to poor pressure).</p> <p>Review of Resident R70's grievance document dated 3/17/25, indicated that she went to the NHA office to file a grievance. She stated a nurse aide was mean to her and would not take care of her the morning of 3/17/25.</p> <p>Review of facility statement from Assistant Director of Nursing (ADON)/Infection Preventionist Employee E8 dated 3/17/25, indicated she heard the Resident R70 voice allegation that Nurse aide was rough with her while she was receiving care.</p> <p>Review of facility statements and reports to the local state field office did not include a report about Resident R70's neglect allegation.</p> <p>During an interview on 4/4/25, at 11:19 a.m. information was disseminated to the Nursing Home Administrator (NHA) that the facility failed to report an allegation of neglect failed to report an allegation of neglect for Resident R70 as required.</p> <p>28 Pa Code: 201.18 (e)(1)(2) Management</p> <p>28 Pa Code: 201.29 (a)(c) Resident Rights</p> <p>(continued on next page)</p>		

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<p>F 0620</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785</p> <p>Based on review of facility policy, resident records, admissions documentation and staff interview it was determined that the facility failed to provide a comprehensive review of resident admission rights and maintain admission documentation for one out of four sampled records (Resident R69).</p> <p>Findings include:</p> <p>The facility Resident rights policy last reviewed 9/18/24, indicated that residents will be informed of their rights and responsibilities.</p> <p>Review of Resident R69's admission record indicated he was admitted on [DATE].</p> <p>Review of Resident R69's MDS assessment (MDS: Minimum Data Set assessment-a periodic assessment of resident care needs) dated 12/20/24, indicated that he had diagnoses that included diabetes (metabolic disorder impacting organ function related to glucose levels in the human body) and dementia (a condition characterized by memory loss and progressive or persistent loss of intellectual functioning), and hypertension (a condition impacting blood circulation through the heart related to poor pressure).</p> <p>Review of Resident R69's Certified Registered Nurse Practitioner (CRNP) progress note dated 12/20/24, indicated that his sister is the surrogate decision maker.</p> <p>Review of Resident R69's clinical records, social service notes, and communications with family did not include an admissions packet or discussion upon admission that included patient portion liability, the daily rate cost structure, resident rights, representative/resident appeal rights, consent to receive treatment, Medicare process, Medicaid process, right to choose ancillary services, bed hold policy, and the consequences for failure to pay.</p> <p>During an interview on 4/1/25, at 12:01 p.m. Medical records personnel Employee E4 provided one sheet of Resident R69 admission record and stated: that is all we have on file.</p> <p>During an interview on 4/1/25, at 3:16 p.m. the Director of Nursing (DON) confirmed that the facility failed to provide a comprehensive review of resident admission rights and maintain admission documentation for Resident R69 as required.</p> <p>28 Pa Code: 201.18 (b)(2) Management.</p> <p>28 Pa Code: 201.24 (a) Admission policy.</p> <p>28 Pa Code: 201.19 (i) Resident rights.</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to complete a significant change Minimum Data Set (MDS- assessments completed indicating a change in condition of a resident requiring change in care) assessment for one of four residents reviewed (Residents R281).</p> <p>Findings include:</p> <p>Review of the Resident Assessment Instrument 3.0 User's Manual (reference used to complete an MDS) effective October 2024, indicated that the facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. A significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan.</p> <p>Review of the clinical record indicated that Resident R281 was admitted to the facility on [DATE].</p> <p>Review of Resident R281's Minimum Data Set (MDS- a periodic assessment of care needs) dated 1/31/25, indicates readmission on 1/29/25, with the diagnosis of hypertension (high blood pressure), malnutrition (lack of proper nutrition) and depression. Section K0510 Nutritional approaches feeding tube checked, indicating present.</p> <p>Review of the Nutrition Admit/Readmit/Annual/Sig Change V10 completed on 1/30/25, for re- admission indicates hospital placement of a percutaneous endoscopic gastrostomy tube (PEG tube - a flexible tube is inserted through the abdominal wall into the stomach).</p> <p>Review of Resident R281's physician orders 1/30/25, indicates enteral feed every shift for nutritional support.</p> <p>Review of resident R 281's care plan date 1/30/25, indicates Resident R281 requires tube feeding (PEG) related to weight loss and failure to thrive. The resident is dependent with tube feeding and water flushes. See physician orders for current feeding orders.</p> <p>Review of Resident R281's MDS assessments revealed a MDS significant change was not completed to include information of the new PEG tube.</p> <p>During an interview completed on 4/4/25, at 3:30 p.m. the Registered Nurse Assessment Coordinator (RNAC) confirmed a significant change MDS was not completed for resident R281, and stated we discussed it and felt it did not need to be completed and confirmed that the facility failed to complete a significant change Minimum Data Set (MDS- assessments completed indicating a change in condition of a resident requiring change in care) assessment for one of four residents reviewed (Residents R281).</p> <p>28 Pa. Code: 211.5(f)(i)(ii)(iii)(iv)(v)(vi)(vii)(ix)(x)(xi) Medical Records</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785</p> <p>Based review of facility policy, clinical records, smoke observations and staff interviews, it was determined that the facility failed to develop and implement comprehensive care plans for one of two sampled residents (Resident R283).</p> <p>Findings include:</p> <p>The facility Smoking policy last reviewed 9/18/24, indicated that the facility has established and maintain safe resident smoking practices. A resident smoke status is evaluated upon admission, quarterly and upon a significant change.</p> <p>Review of Resident R283's admission record indicated he was admitted on [DATE].</p> <p>Review of Resident R283's new admission nurse evaluation dated 3/27/25, indicated he had diagnoses that included hypertension (a condition impacting blood circulation through the heart related to poor pressure), hyperlipidemia (elevated lipid levels within the blood), and history of alcohol abuse.</p> <p>Review of Resident R283's smoke evaluation dated 3/27/25, indicated that he was identified as a smoker, he must be supervised during smoking, and he must wear a smoke apron at all times during smoke breaks.</p> <p>Review of Resident R283's care plans dated 3/31/25, did not indicate that he was a smoker or took smoke breaks.</p> <p>During smoke break observations on 4/4/25, at 10:07 a.m. Resident R283 was observed smoking outside with eight other residents. Resident R283 was observed without a smoke apron.</p> <p>During an interview on 4/4/25, at 10:21 a.m Registered Nurse Assessment Coordinator (RNAC) Employee E23 confirmed that the facility failed to develop and implement comprehensive care plans</p> <p>28 Pa.Code: 211.11 (a)(c)(d) Resident care plan.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>27424</p> <p>Based on review of facility documentation, interview with residents and observations the facility failed to implement an activities program that met residents needs for four of six residents (Resident R300, R301, R302 and R303).</p> <p>Findings include:</p> <p>During resident interviews on 4/1/25 and 4/2/25 residents indicated that they did not feel the activities were meeting their needs. Resident R300, R301, R302, and R303 indicated they would like to have different types of activities, more variety, outside activities, to include if you don't smoke being able to go outside, creative and challenging activities, that keep them interested in things. They feel like there aren't sufficient activities to keep them interested.</p> <p>Review of the resident activity calendars from:</p> <p>January with facility activities ending at 2pm in Janaury of 2025</p> <p>For February of 2025 activities ending at 3pm on 4 days of the month (the other activities ending at 2pm.</p> <p>March activities ending at 3pm.</p> <p>Review of the resident activity calendar indicated that independent activites included word searches, board games, reading, puzzles, television, and games.</p> <p>Review of activity calendar for March indicated bingo was held at the same time as smoking with over 15 residents smoking who would not be able to attend the bingo activity.</p> <p>Review of the activity calendars failed to indicate which nursing unit the activities were being held on and where.</p> <p>Review of clinical records for two residents failed to include any documentation of residents attending activities. Review of two other residents included one note of residents involvement in activities from January to April and October to April.</p> <p>During an interview on 4/5/25, at 2:14p.m. NHA confirmed that the activities program failed ot have documentation showing involvement from residents in the current activity program and the activity program failed to meet resident needs.</p> <p>28 Pa. Code: 201.18(b)(3) Management.</p> <p>28 Pa. Code : 211.10 (d) Resident care policies.</p>		

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<p>F 0680</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the activities program is directed by a qualified professional.</p> <p>27424</p> <p>Based on review of facility documentation and staff interview it was determined that the facility failed to employed a qualified activities director from October of 2024 to April of 2025.</p> <p>Findings include:</p> <p>Federal Regulation indicates the following:</p> <p>S483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who-</p> <p>(i) Is licensed or registered, if applicable, by the State in which practicing; and</p> <p>(ii) Is:</p> <p>(A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or</p> <p>(B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or</p> <p>(C) Is a qualified occupational therapist or occupational therapy assistant; or</p> <p>(D) Has completed a training course approved by the State.</p> <p>Review of Activity Director Employee E25 file failed to include any of the above documentation or information.</p> <p>During an interview on 4/4/25, at 2:28 p.m. Activity Director Employee E25 indicated that they did not have any of the above requirements.</p> <p>During an interview on 4/5/25, at 2:15 p.m. Nursing Home Administrator confirmed that the facility failed to have a qualified Activity Director.</p> <p>28 Pa. Code 201.18 (b)(3)(e) (6) Management.</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>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27424</p> <p>Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to make certain that residents were provided appropriate treatment and care for two of four residents (Resident R4 and R77).</p> <p>Findings include:</p> <p>Review of facility policy Administering Medications dated 2/12/25, indicated medications are administered in accordance with prescriber order, including any required time frame.</p> <p>Resident R4 was admitted to the facility on [DATE].</p> <p>Review of Resident R4 MDS (minimum data set - a periodic assessment of resident needs) dated 2/26/25, had diagnosis of atrial fibrillation (irregular and often very rapid heart rhythm), neoplasm of breast (kind of breast cancer that begins in the cells of of the breast tissue) and osteoarthritis (joint disease in which tissues break down over time).</p> <p>Review of Resident R4 clinical record included hospital discharge record with physician order for a pureed diet.</p> <p>Review of resident R4 clinical record physician orders failed to include a pureed diet until 2/24/25 - three days after Resident R4 was admitted .</p> <p>During an interview on 4/5/25, at 12:12 p.m. DON (Director of Nursing) confirmed that the physician orders for the facility failed ot include the purred diet until three days after Resident R4 admit and the facility failed to provided appropriate treatment and services for Resident R4.</p> <p>Review of the clinical record indicated Resident R77 was admitted to the facility on [DATE], with diagnoses of respiratory failure, immunodeficiency, and kidney transplant rejection.</p> <p>Review of Resident R77's hospital discharge summary dated 3/3/25, revealed the resident's 10-325 mg Hydrocodone-Acetaminophen (combination medication used to relieve moderate to severe pain), one tablet by mouth every 6 hours as needed for pain was discontinued.</p> <p>Review of a physician order dated 3/4/25, indicated to administer 10-325 mg Hydrocodone-Acetaminophen Oral, one tablet by mouth every 6 hours as needed for pain.</p> <p>Review of Resident R77's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/7/25, indicated diagnoses were current.</p> <p>Review of Resident R77's March 2025 Medication Administration Record revealed the resident received 10-325 mg Hydrocodone-Acetaminophen, one tablet by mouth every 6 hours as needed for pain a total of 19 times in March.</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>During an interview on 4/1/25, at 11:50 a.m. Registered Nurse Supervisor, Employee E2 confirmed Resident R77's 10-325 mg Hydrocodone-Acetaminophen, one tablet by mouth every 6 hours as needed for pain should have not be ordered and was discontinued at the hospital. RN Supervisor, Employee E2 confirmed the facility failed to make certain that residents were provided appropriate treatment and care for one of four residents (Resident R77).</p> <p>During an interview on 4/5/25, at 4:45 p.m. the Director of Nursing and Nursing Home Administrator confirmed the facility failed to make certain that residents were provided appropriate treatment and care for two of four residents (Resident R4 and R77).</p> <p>28 Pa. Code 201.18 (b)(1) Management.</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 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</p> <p>Based on review of facility documents, clinical records, and resident and staff interviews, it was determined that the facility failed to ensure that residents had proper assistive devices to maintain adequate hearing for one of two residents reviewed (Resident 34).</p> <p>Findings include:</p> <p>Review of the facility Hearing Impaired Resident, Care of dated 9/18/24, revealed staff will assist hearing impaired residents to maintain effective communication with clinician, caregivers, other residents and visitors. Staff will assist the resident (or representative) with locating available resources, scheduling appointments, and arranging transportation to obtain needed services. Staff must assist residents with the care and maintenance of hearing devices, and help those who have lost or damaged hearing devices in obtaining services to replace devices.</p> <p>Review of Resident R34's clinical record revealed that Resident R34 was admitted to the facility on [DATE], with diagnoses of tracheostomy (tube inserted through the neck to assist breathing) status, repeated falls, and gastro-esophageal reflux disease without esophagus (also known as GERD, occurs when stomach acid frequently flows back into the esophagus, leading to irritation and discomfort.)</p> <p>Review of Resident 34's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/28/25, indicated diagnoses were current.</p> <p>During an interview on 3/31/25, at 10:08 a.m. Resident R34 was observed to be hard of hearing. Resident R34 indicated she did not have her hearing aids with her.</p> <p>Review of Resident R34's clinical record on 3/31/25, failed to include a care plan and interventions related to the resident being hard of hearing.</p> <p>During an interview on 4/5/25, at 11:16 a.m. Registered Nurse Supervisor, Employee E2 confirmed Resident R34 is hard of hearing and the facility does not have the resident's hearing aids, the family does. RN Supervisor, Employee E2 stated to communicate with Resident R34, staff must stand in front of the resident and talk loudly. RN Supervisor, Employee E2 confirmed Resident R34 was not care planned for being hard of hearing.</p> <p>During an interview on 4/5/25, at 11:19 a.m. the Director of Nursing confirmed the facility failed to ensure that residents had proper assistive devices to maintain adequate hearing for one of two residents reviewed (Resident 34).</p> <p>28 Pa. Code 201.29(j) Residents Rights.</p> <p>28 Pa. Code 211.12(d)(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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</p> <p>Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to make certain that residents received the necessary services and ensure wound care recommendations were implemented timely for one of four residents (Resident R16).</p> <p>Findings include:</p> <p>Review of the facility Pressure Injury Risk assessment dated [DATE], indicated risk factors that increase a resident's susceptibility to develop or not heal pressure injuries include impaired/decreased mobility and exposure of skin to urinary and fecal incontinence or other sources of moisture.</p> <p>Review of the facility Pressure Ulcers/Skin Breakdown policy dated 9/18/24, indicated staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers. The physician will order pertinent wound treatments, including application of topical treatments.</p> <p>Review of the facility Care Plans, Comprehensive Person-Centered policy dated 9/18/24, revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs in developed and implemented for each resident.</p> <p>Review of the admission record indicated Resident R16 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced), hemiplegia (paralysis that affects only one side of the body) following affecting the left non-dominant side, and anxiety.</p> <p>Review of Resident R16's progress note dated 2/10/25, revealed the resident was evaluated for a partial thickness sacrum moisture associated skin damage wound. The wound reopened and measured 3.5 centimeters (cm) x 0.4 cm x 0.2 cm. Recommendation indicated to cleanse wound with soap and water, apply medical grade honey to base of wound, secure with bordered gauze, and change daily and as needed. Ensure treatment and dressings are applied daily.</p> <p>Review of Resident R16's Minimum Data Set (MDS - periodic assessment of care needs) dated 3/18/25, indicated the diagnoses were current.</p> <p>Review of Resident R16's wound care note dated 3/24/25, indicated the resident's wound to the sacrum was resolved. Recommendations indicated to continue use of Triad paste twice a day for skin protection. The resident was at risk for skin breakdown related to decreased mobility, comorbidities, incontinence of urine and stool.</p> <p>Review of Resident R16's care plan dated 3/24/25, indicated the resident needs a pressure redistribution to protect skin while in bed due to small pressure ulcer on buttocks area.</p> <p>Review of Resident R16's clinical record on 4/1/25, at 10:38 a.m. failed to include an active physician order for the barrier cream as recommended by the facility's wound care provider on 3/24/25.</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 4/1/25, at 10:40 a.m. Nurse Aide, Employee E25 stated Resident R16 was changed and their buttock was excoriated. It was indicated the resident told NA, Employee E25 how itchy it was.</p> <p>During an interview on 4/1/25, at 10:41 a.m. Licensed Practical Nurse, Employee E1 confirmed Resident R16 did not have an order for barrier cream as recommended by the wound care provider.</p> <p>During an interview on 4/3/25, at 2:22 p.m. Wound Care Nurse Practitioner, Employee E14 stated Triad paste was recommended for Resident R16 and it is expected facility staff implement wound care recommendations the next day if the product is available. If wound care supplies are not available, the wound care provider should be notified and a new order can implemented until the supplies arrive.</p> <p>During an interview on 4/3/25, at 3:21 p.m. the Director of Nursing confirmed the facility failed to make certain that residents received the necessary services and ensure wound care recommendations were implemented timely for one of four residents (Resident R16).</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)(3)(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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469</p> <p>Based on facility policy, clinical record review, and interview, the facility failed to have physician order specifications relating to size of indwelling catheter (a thin, flexible tube inserted into the bladder through the urethra to drain urine) and balloon inflation amount (secures catheter to bladder) for one of three residents (Resident R48).</p> <p>Findings include:</p> <p>Review of the facility policy Catheter Care, Urinary dated 9/18/25, indicated the purpose of this procedure is to prevent urinary catheter associated complications including urinary tract infections. Review the residents care plan to assess for any special needs of the resident.</p> <p>Review of Admission record indicated Resident R48 was admitted to the facility on [DATE].</p> <p>Review of Resident R48's Minimum Data Set (MDS- a periodic assessment of care needs) dated 2/14/25, indicated diagnoses of obstructive uropathy (blockage of the urinary flow), hypertension (high blood pressure) and heart failure (the heart doesn't pump the way it should). Section H0100 indicated indwelling foley catheter use.</p> <p>Review of resident R48's physician order dated 2/14/25, indicated ensure foley catheter care is done every shift and ensure catheter is secured to leg.</p> <p>Review of Resident R48's physician orders dated 2/14/25, indicated apply drainage bag when in bed every evening and night shift for foley bag</p> <p>Review of Resident R48's physician order dated 3/30/25, indicated enhanced barrier precautions for foley catheter.</p> <p>Review of Resident R48's physician orders on 4/4/25, failed to include specifications for size and balloon inflation amount for the indwelling foley catheter.</p> <p>Interview on 4/4/25, at 2:28 p.m. the Director of Nursing confirmed Resident R48's clinical record failed to provide specifications for size and balloon inflation amount of the indwelling catheter and that the facility failed to have physician order specifications relating to size of an indwelling catheter and balloon inflation amount for one of three residents (Resident R48).</p> <p>28 Pa. Code 201. 18(b)(1) Management.</p> <p>28 Pa code:211.10(c)(d) Resident care policies.</p> <p>28 Pa Code:211.12(c)(d)(1)(2)(5) Nursing services.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</p> <p>Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to ensure a resident received sufficient fluid intake to maintain proper hydration and health for one of four residents (Residents R20) and address a significant weight loss for one of four residents (Resident R68).</p> <p>Findings include:</p> <p>Review of facility policy Weighting and Measuring the Resident dated 9/18/24, indicated weights will be obtained to provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident. The weight and all assessment data obtained while weighing the resident must be documented in the resident's medical record. Report significant weight loss/ weight gain to the nurse supervisor. The threshold of significant unplanned and undesired weight loss for one month is 5%, greater than 5% is severe.</p> <p>Review of facility policy Nutritional assessment dated [DATE], revealed the dietician, in conjunction with nursing staff and healthcare practitioners will conduct a nutritional assessment for each resident as indicated by a change in condition that places the resident at risk for impaired nutrition. The dietician will assess whether the resident's current intake is adequate to meet his or her nutritional needs. Usual body weight, current height and weight, a history of progressive weight loss, and food restrictions will be included in nutritional assessments.</p> <p>Review of the clinical record indicated Resident R20 was admitted to the facility on [DATE].</p> <p>Review of Resident R20's care plan dated 2/6/25, revealed the resident was on a fluid restriction. A 1500 milliliters (ml) total fluid restriction, 1080 ml/day for dietary and 420 ml for nursing. Interventions included to provide, serve diets ordered and to monitor intake and record every meal. Weigh as same time of day and record.</p> <p>Review of Resident R20's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/10/25, indicated diagnoses of dependence on renal dialysis (acts like an artificial kidney, removes waste and fluid from the body), end stage renal disease (the final stage of chronic kidney disease where the kidney can no longer filter waste and excess fluids from the blood effectively), and heart failure (a condition where the heart muscle doesn't pump blood as well as it should).</p> <p>Review of Resident R20's physician order dated 2/7/25, revealed the resident was on a 1500 ml fluid restriction in 24 hours. The resident was ordered a fluid restriction of 275 ml for the daylight and evening shift, and a 100 ml for the night shift for nursing. The resident was ordered a 750 ml fluid restriction for dietary.</p> <p>Review of Resident R20's active physician order dated 3/31/25, revealed the resident was on a 1500 milliliters (ml) fluid restriction in 24 hours. The resident was ordered a fluid restriction of 160 ml for the daylight and evening shift, and a 100 ml for the night shift for nursing. The resident was ordered 1080 ml fluid restriction for dietary.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R20's active physician order dated 3/31/25, indicated to administer Nepro with Carb Steady (a therapeutic nutrition specifically designed to help meet the needs of people on dialysis) one time a day at lunch.</p> <p>Review of Resident R20's clinical record on 4/4/25, at 1:52 p.m. failed to include evidence the facility documented the total amount of fluids the resident consumed each shift. A further review of the resident's physician orders failed to include an order to weigh the resident at the same time daily as the care plan indicated.</p> <p>During an observation and interview on 4/4/25, at 2:01 p.m. Resident R20 was observed to have a 16 ounce (equivalent to 473 ml) Styrofoam cup of water at the bedside. The resident already consumed the cup of water and stated I drink about two of those a day. Resident R20 stated I always get protein drinks, I love them. A 4 ounce carton of apple juice was observed on the resident's bedside table. Resident R20's breakfast meal ticket dated 4/4/25, was located on the resident's bedside table. It indicated Resident R20 was on a fluid restriction, No orange juice or other fluids. A further review of Resident R20's meal ticket revealed the resident received a 8 oz milk, 4 oz juice, and 8 oz tea.</p> <p>During an interview on 4/4/25, at 2:05 p.m. the Director of Nursing confirmed that the facility failed to document the amount of fluid intake to ensure the resident received their fluid restriction as ordered.</p> <p>During an interview on 4/4/25, at 3:24 p.m. the DON and Nursing Home Administrator confirmed the facility failed to provide care and services to maintain acceptable parameters of nutritional status for Resident R20.</p> <p>Review of the clinical record indicated Resident R68 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident R68's care plan revealed the resident had a tube feed. Interventions included to have registered dietician evaluate and make tube feed/flush recommendations as needed, weigh at same time of day and record.</p> <p>Review of Resident R68's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/9/25, indicated diagnoses of high blood pressure, dementia he loss of cognitive functioning- thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities.), and end stage renal disease (the final stage of chronic kidney disease where the kidney can no longer filter waste and excess flids from the blood effectively).</p> <p>Review of Resident R68's clinical record revealed the following weight recorded.</p> <p>3/6/25-181.2 pounds (lbs)</p> <p>4/1/25- 155 lbs (Significant weight loss of 14.46% in less than one month)</p> <p>During an interview on 4/5/25, at 9:13 a.m. Director of Clinical Operations, Employee E24 indicated if a resident has a significant weight loss, another weight should be obtained to ensure accurately.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident R68's clinical record on 4/1/25, at 9:17 a.m. failed to include evidence the resident was reweighed or the dietician addressed the resident's significant weight loss.</p> <p>During an interview on 4/5/25, at 9:23 a.m. the Director of Nursing stated if a resident has weight loss, staff are expected reweigh the resident and notify the Director of Nursing, then consult the dietician. Registered Dietician, Employee E7 comes into the facility every Thursday and reviews all the residents who had weight loss. The DON stated he was aware of Resident R68's significant weight loss and confirmed the facility failed to evaluate and address resident R68's weight loss.</p> <p>During a phone interview on 4/5/25, at 9:52 a.m. Registered Dietician, Employee E7 stated residents who have a significant weight loss must be reweighed to ensure accuracy. A weekly meeting is conducted with the DON, every Thursday to review resident's with weight loss. Registered Dietician, Employee E7 indicated he was unaware of Resident R68's weight loss.</p> <p>During an interview on 4/5/25, at 4:45 p.m. the Director of Nursing and Nursing Home Administrator confirmed the facility failed to ensure a resident received sufficient fluid intake to maintain proper hydration and health for one of four residents (Residents R20) and address a significant weight loss for one of four residents (Resident R68).</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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469</p> <p>Based on review of facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that residents with an enteral feeding tube (PEG - a tube inserted in the stomach through the abdomen) received appropriate treatment and services to prevent potential complications for one of two residents (Residents R281).</p> <p>Findings include:</p> <p>Review of facility policy Enteral Nutrition last reviewed 9/18/24, indicated adequate nutritional support through enteral nutrition is provided to residents as ordered. The use of enteral nutrition is based on the results of the comprehensive nutritional assessment, and is consistent with current standards of practice, the resident's advance directives, treatment goals and facility policy.</p> <p>Review of the clinical record indicated that Resident R281 was admitted to the facility on [DATE].</p> <p>Review of Resident R281's Minimum Data Set (MDS- a periodic assessment of care needs) dated 1/31/25, indicates readmission on 1/29/25, with the diagnosis of hypertension (high blood pressure), malnutrition (lack of proper nutrition) and depression. Section K0510 Nutritional approaches feeding tube checked, indicating present.</p> <p>Review of the Nutrition Admit/Readmit/Annual/Sig Change V10 completed on 1/30/25, for re- admission indicates hospital placement of a percutaneous endoscopic gastrostomy tube (PEG tube a flexible tube is inserted through the abdominal wall into the stomach).</p> <p>Review of Resident R281's physician orders dated 1/30/25, indicate Enteral Feed every shift for Nutritional Support Nutren 2.0-start 10 cubic centimetre (cc) per hour (hr) via PEG Tube and increase 10cc every (q) 12 hrs to goal rate of 40cc/hr x 20 hrs per day- allow 1 hour off before and after Synthroid administration for a total volume of 800cc.</p> <p>Review of resident R 281's care plan date 1/30/25, initiated Resident R281 requires tube feeding (PEG) related to weight loss and failure to thrive. The resident is dependent with tube feeding and water flushes. See physician orders for current feeding orders.</p> <p>Review of Resident R281's physician orders dated 2/17/25, indicate regular diet, puree texture, thin consistency diet.</p> <p>During an observation on 4/1/25, at 9:21 a.m. Resident R281 was sitting in her chair in the 4th floor common area across from the nursing station, her tube feed pump (device used to deliver liquid nutrition through the feeding tube at a controlled rate) was alarming with a beeping sound and was placed on hold.</p> <p>During an observation on 4/1/25, at 10:13 a.m. the tube feeding pump was in the 4th floor common area the delivery tubing was disconnected from the resident and the end connection port was uncapped allowing the formula to drip onto the floor.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview completed on 4/1/25, at 10:16 a.m. Licensed Practical Nurse (LPN) Employee E9 indicated Resident R281 had been returned to her room for care. LPN Employee E9 confirmed the delivery tubing was uncapped allowing formula to drip onto the floor. LPN Employee further commented I will reconnect it after her care is completed, I will just wash it off (end connection port). Upon asking what the current formula rate is LPN Employee E9 stated it is on 40 cc/hr.</p> <p>During an interview completed on 4/3/25, at 2:01 p.m. upon asking Registered Dietician (RD) Employee E7 how to determine the current rate of delivery for Resident R281 he replied you would look at the pump further inquiry concerning the physician orders RD Employee E7 stated R281's tube feeding should be set at 40 cc/hr , I have no idea why the order was not changed to show the current running rate, it was supposed to be tapered up and the PEG was new, it should have been spelled out per day starting at 10cc/hr, increasing the next day to 20 cc/hr, then next day 30 cc/hr, until it reached 40 cc/hr. It doesn't look like any way to identify the current rate of the feeding. Upon asking if Resident R281 is also receiving meals per oral intake and if the feeding should be shut off during this time. RD Employee E7 stated she can be off for at least two meals the time allowed would be for four hours, lunch time should be off and confirmed the current orders did not include the parameters for the tube feeding down time to allow for the oral intake.</p> <p>During an interview completed on 4/5/25, at 9:25 a.m. the Director of Nursing (DON) confirmed the tube feeding orders were up not updated to the current run rate. Upon review of the current care plan the DON stated the care plan indicated to see physician orders for current feeding orders, I see the orders says goal rate, I can't figure it out and confirmed that the facility failed to ensure that residents with an enteral feeding tube (PEG a tube inserted in the stomach through the abdomen) received appropriate treatment and services to prevent potential complications for one of two residents (Residents R281).</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p> <p>28 Pa. Code: 211.10(c) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1) Nursing services.</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</p> <p>Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to implement a care plan for intravenous therapy for one residents of two residents (Resident R24).</p> <p>Findings include:</p> <p>Review of the facility Care Plans, Comprehensive Person-Centered policy dated 9/18/24, revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs in developed and implemented for each resident.</p> <p>Review of Resident R24's clinical record indicates an admitted [DATE], with the diagnosis of high blood pressure, cellulitis (bacterial infection of skin) of left lower limb, and sepsis (a serious condition that occurs when the body has extreme reaction to an infection).</p> <p>Review of Resident R24's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/2/25, indicated diagnoses were current.</p> <p>Review of physician orders dated 2/25/25, indicated to change Resident R24's PICC line (thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart) dressing weekly on night shift using sterile technique.</p> <p>Review of Resident R24's clinical record on 4/5/25, at 10:48 a.m. failed to include a care plan for the resident's PICC line.</p> <p>During an observation on 4/5/25, at 10:51 a.m. Resident R24 was observed with a PICC line intact.</p> <p>During an interview on 4/5/25, at 10:55 a.m. Director of Nursing confirmed the facility failed to implement a care plan for intravenous therapy for one residents of two residents (Resident R24).</p> <p>28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</p> <p>Based on observation, review of clinical record, review of facility policies, interview with staff and resident, it was determined the facility failed provide tracheostomy care consistent with professional standards of practice for two of two residents. This failure resulted in an Immediate Jeopardy situation for Resident R32 and R34 who had a tracheostomy obstruction, experienced respiratory and emotional distress and potential death. (Resident R34)</p> <p>Findings include:</p> <p>Review of the facility policy Tracheostomy Care Protocol Licensed Staff last reviewed [DATE], indicates respiratory care must be provided per professional standards, physician orders are required for all aspects of tracheostomy (trach) care, including suctioning and oxygen use. Care plans must be resident-specific, updated upon condition change, and interdisciplinary. A baseline care plan must be developed within 48 hours of admission for all resident with a tracheostomy. Step by step tracheostomy care education for licensed staff includes but not inclusive to:</p> <ul style="list-style-type: none"> A. Preparing for trach care: Review residents care plan and orders. B. Explaining the procedure C. Suctioning (if needed prior to cleaning) D. Inner Cannula care E. Stoma and skin care F. Dressing and ties G. Oxygen and humidification management H. Monitoring I. Emergency Preparedness J. Infection prevention K. Resident -centered considerations <p>Tracheostomy monitoring and infection prevention:</p> <ul style="list-style-type: none"> II. Signs and symptoms of tracheostomy infection III. How to obtain a trach culture IV. Documentation and reporting <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the admission record indicated R32 was admitted to the facility on [DATE], with the diagnosis of respiratory failure (lungs have trouble loading your blood with oxygen), heart failure (heart doesn't pump the way it should), and tracheostomy (surgical hole in the windpipe that helps with breathing) status.</p> <p>Review of Resident R32's Minimum Data Set (MDS- assessment of resident's care needs) dated [DATE], section C0200 BIMS (Brief interview for mental status) revealed that Resident R32 scored 13 which indicated that Resident R32 was cognitively intact. Review of section O (Special treatments and procedures) 0110, C1 (oxygen therapy) and E1 (tracheostomy care) confirmed that Resident R32 received oxygen and tracheostomy care. Section D1 (suctioning) revealed suctioning completed.</p> <p>Review of Resident R32's care plan initiated [DATE], with revision on [DATE], indicated Respiratory: Resident has a tracheostomy related to impaired breathing mechanics; diagnosis of chronic obstructive pulmonary disease (COPD) and is dependent with oxygen since 2017. Resident is self-sufficient with trach care, including cleaning and changing inner cannula and suctioning as needed.</p> <p>Review of Resident R32's physician orders dated [DATE], indicated check stoma weekly as needed for diagnosis of tracheostomy status check stoma site for skin breakdown/maintenance, order was discontinued on [DATE], at 2:02 p.m.</p> <p>Review of Resident R32's physician orders dated [DATE], indicated tracheostomy care check stoma every evening shift for diagnosis of tracheostomy status check stoma site for skin breakdown, order was discontinued on [DATE], at 2:02 p.m.</p> <p>Review of Resident R32's physician order dated [DATE], indicated tracheostomy care - ensure clean ties daily every evening shift. clean ties daily, order was discontinued on [DATE], at 2:02 p.m.</p> <p>Review of Resident R32's physician orders dated [DATE], indicated tracheostomy care - ensure clean ties daily as needed for diagnosis of tracheostomy status clean ties for trach, orders were discontinued on [DATE], at 2:02 p.m.</p> <p>Review of Resident R32's physician orders dated [DATE], indicated change inner cannula daily Shiley XLT 6. 0 every day shift for diagnosis of tracheostomy status, order was discontinued on [DATE], at 2:02 p.m.</p> <p>Review of Resident R32's physician orders dated [DATE], indicated oxygen 6 liters to maintain oxygen (O2) sat greater than 92% via trach mask. every shift for oxygen dependency, order was discontinued on [DATE], at 2:02 p.m.</p> <p>Review of Resident R32's nursing progress notes dated [DATE], 2:29 p.m. indicated resident was discovered on floor face down in moderate amt pooled blood. Wound to head actively bleeding. No loss of consciousness noted. Resident remained alert and oriented to baseline throughout assessment. Complained of back, left leg and head pain. Unable to obtain VS due to position on floor. EMS called for emergency transport to hospital per Resident request. Physician notified.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident R32's nursing progress notes dated [DATE], 2:29 p.m. indicated resident was transferred to hospital.</p> <p>Review of Resident R32's nursing progress note dated [DATE] 6:18 p.m. resident admitted to hospital with diagnosis of encephalopathy.</p> <p>Review of Resident R32's nursing progress note dated [DATE], at 8:00 p.m. indicated Resident R32 returned from hospital. Alert and oriented X4 with no confusion. Admits to pain of 6. Pupils equal, round, reactive to light accommodation (Perrla). Diagnosis of urinary tract infection (UTI) now with 16F foley (tube inserted into the bladder) draining clear yellow urine without difficulties. Vital within in normal limits (wnl) of resident baseline. Trach intact with 6XLT Shiley. No noted fever. Pills whole, regular diet with thin liquids. bed in lowest position. Resident is able to make her needs known. call light within reach. will continue to monitor.</p> <p>Review of Resident R32's re-admission assessment dated [DATE], form V10.8 indicated tracheostomy present.</p> <p>Review of Resident R32's current physician orders on [DATE], failed to include current orders for tracheostomy care.</p> <p>Review of Resident R32's [DATE] medication administration record (MAR) indicated trach care discontinued on [DATE].</p> <p>Review of Resident R32's [DATE] MAR indicated tracheostomy Care - Ensure clean ties daily was discontinued on [DATE].</p> <p>Review of Resident R32's [DATE] MAR indicated Oxygen 6 liters to maintain O2 sat greater than 92% via trach mask. every shift for Oxygen Dependency was discontinued on [DATE].</p> <p>Review of Resident R34's clinical record revealed that Resident R34 was admitted to the facility on [DATE], with diagnoses of tracheostomy (tube inserted through the neck to assist breathing) status, repeated falls, and hip fracture.</p> <p>Review of Resident R34's physician's order dated [DATE], indicated to administer 10 liters (L) of oxygen via trach mask every shift for oxygen dependency.</p> <p>Review of Resident R34's progress note dated [DATE], revealed the resident has a tracheostomy and was on three liters of oxygen. The facility failed to administer oxygen as ordered or notify physician of the change in oxygen demand.</p> <p>Review of Resident R34's progress note dated [DATE], indicated trach care was provided and Registered Nurse (RN), Employee E12 was unable to insert inner cannula. The resident was taken to the hospital for evaluation.</p> <p>Review of Resident R34's progress note dated [DATE], revealed Licensed Practical Nurse (LPN), Employee E13 went into the resident's room to answer her call light and the resident was found holding her trach in her hand and was unable to put it back in. The supervisor was notified and 911 was called.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident R34's Minimum Data Set (MDS- assessment of resident's care needs) dated [DATE], section C0200 BIMS (Brief interview for mental status) revealed that Resident R34 scored 13 which indicated that Resident R34 was cognitively intact.</p> <p>Review of section O (Special treatments and procedures) 0110, C1 (oxygen therapy) and E1 (tracheostomy care) confirmed that Resident R34 received oxygen and tracheostomy care. Section D1 (suctioning) revealed suctioning was not a treatment that was performed.</p> <p>Review of Section GG (Functional Abilities) reveled that Resident R34 required supervision or touching assistance in bed mobility and required substantial/maximal assistance with transfers.</p> <p>Review of Resident R34's baseline care plan dated [DATE], failed to include a care plan for suctioning, tracheostomy care, and isolations precautions. The facility failed to implement a baseline care plan within 48 hours of admission.</p> <p>Review of Resident R34's progress note dated [DATE], revealed the resident required significant assistance for ADL (activity of daily living) tasks. It was indicated nursing was working on trach care, the son was going to bring in cleaning supplies as resident completed this on her own before.</p> <p>Review of Certified Registered Nurse Practitioner, Employee E15 progress note dated [DATE], revealed the resident was assessed and the resident had a history of laryngeal cancer and had a permanent trach. It was indicated to have respiratory therapy as ordered.</p> <p>Review of Resident R34's progress note dated [DATE], revealed the RN Supervisor notified Assistant Director of Nursing, Employee E8 that Resident R34 was having respiratory difficulties intra cannula from trach was dislodged. The resident was transferred to the hospital.</p> <p>Review of Resident R34's progress note dated [DATE], indicated the resident's inner cannula was removed and staff were unable to reinsert. The resident stated she can breathe easier with the inner cannula out. RN, Supervisor, Employee E2 indicated the hospital discharge paperwork were reviewed to identify next steps.</p> <p>Review of Resident R34's physician order dated [DATE], indicated the resident was scheduled a tracheostomy evaluation on [DATE], at 10:00 a.m.</p> <p>Review of Resident R34's physician order dated [DATE], indicated to obtain a culture one time only for trach infection site on [DATE].</p> <p>Review of Resident R34's [DATE] Treatment Administration Record (TAR) failed to indicate Resident R34's culture was obtained as ordered.</p> <p>Review of Resident R34's care plan dated [DATE], revealed the resident had a tracheostomy. The resident's goal was to have no signs and symptoms of infection. Interventions included to ensure trach ties are secure and monitor/document for restlessness, agitation, confusion, increased heart rate, and bradycardia. It was indicated to monitor/document respiratory rate, depth, and quality every shift/as ordered, and to suction as necessary. The care plan failed to include tracheostomy care including, cleaning and the size of the inner cannula.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident R34's physician order dated [DATE], indicated to administer one tablet of 100 milligram (mg) Doxycycline Hyclate (antibiotic that treat bacterial infections) by mouth, two times a day for infection for 10 days.</p> <p>Review of Certified Registered Nurse Practitioner, Employee E15 progress note dated [DATE], revealed Resident R34 had recent concerns for trach maintenance and care.</p> <p>Review of Resident R34's physician order dated [DATE], indicated to obtain a culture one time only for trach infection site.</p> <p>Review of Resident R34's office visit summary dated [DATE], revealed the resident was referred to see an otolaryngology (ear, nose, and throat, is a medical specialty that focuses on the diagnosis and treatment of conditions affecting the ears, nose, throat, and related structures of the head and neck) provider for a consultation for the resident's tracheostomy status. Resident R34 used a metal [NAME] tracheostomy tube. While a resident at a skilled nursing facility, Resident R34's inner cannula dislodge, and staff were unable to reinsert and the resident was sent to the hospital. Resident R34 was transferred to the hospital and underwent a laparoscopy (a surgical procedure in which a small incision is made through which a viewing tube is inserted) which showed some circumferential mucus making reinsertion challenging. A saline irrigation and suctioning was performed to remove the crusting, and then a new inner cannula was inserted. Resident R34 presented a month later, on [DATE], with the inability to place the inner cannula. The assessment revealed Resident R34's metal [NAME] tracheostomy has progressively gotten obstructed and with a biofilm. Redness was observed around the skin of Resident R34's tracheostomy. Upon examination, Resident R34 had a complete obstruction of the tracheostomy. An inner cannula was unable to be placed. The tracheostomy tube was removed and the inside of both the trach and the inner cannula was extensively cleaned. Resident R34's trach was replaced and Resident R34 was observed to be clear and was able to breathe significantly better. Prior to this, Resident R34 had inspiratory stridor (a high-pitched sound that occurs when breathing through a narrow or obstructed airway, indicating difficulty in breathing. It can be a sign of an abnormality in the airway that may require medical attention). The plan was to start antibiotics for low grade tracheostomy infection, diligent trach care, 20 mg famotidine (medication that decreases stomach acid production), one tablet, for reflux symptoms, change 40 mg pantoprazole (use to treat certain stomach and esophagus problems), one tablet, to 30 minutes before dinner, and to follow up in one month.</p> <p>Review of Resident R34's physician order dated [DATE], indicated to administer one table of ,d+[DATE] mg Amoxicillin-Pot Clavulanate (a combination antibacterial medication used to treat various types of bacterial infections), one tablet by mouth every 12 hours for a tracheostomy bacterial infection for 10 days.</p> <p>Review of Resident R34's physician orders dated [DATE], indicated to administer 10 mg famotidine, one tablet by mouth, one time a day for reflux. The facility failed to ensure Resident R34 received 20 mg of famotidine as ordered by the provider at the office visit on [DATE].</p> <p>Review of Resident R34's physician orders revealed multiple orders for pantoprazole. Resident R34 was ordered 40 mg pantoprazole, one tablet, once a day on [DATE], and 20 mg of pantoprazole, one tablet, once a day on [DATE]. Review of Resident R34's March MAR revealed Resident R34 received both orders of pantoprazole, a total of 60 mg on seven days. The facility failed to ensure Resident R34 received 40 mg pantoprazole before dinner as ordered by the provider at the office visit on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident R34's progress note dated [DATE], entered by LPN, Employee E13 indicated trach care was performed. The facility failed to have an order for trach care and the size of the inner cannula.</p> <p>During an interview on [DATE], at 10:08 a.m. Resident R34 was observed lying in bed, not wearing 10 liters of oxygen as ordered. The oxygen was observed across the room, turned off, without tubing, and not within reach of the resident. The resident stated I never had to wear oxygen. Resident R34 was tearful and stated staff do not know how to care for the tracheostomy. It was indicated prior to being admitted to the facility, the facility indicated staff can provide care for residents with a tracheostomy. An undated gallon of distilled water was observed open and on the floor. Resident R34 indicated the gallon of distilled water was used for trach care.</p> <p>During an interview on [DATE], at 11:26 a.m. LPN, Employee E1 was asked if they were trained on tracheostomy care. LPN, Employee E1 indicated it was their first day and the facility did not train or educate LPN, Employee E1 on tracheostomy care. LPN, Employee E1 confirmed they were assigned to Resident R34 and indicated they had experience in pediatric trach care. LPN, Employee E1 confirmed Resident R34 was not receiving oxygen as ordered.</p> <p>During an interview on [DATE], at 11:20 a.m. RN Supervisor, Employee E2 confirmed Resident R34's tracheostomy culture was not completed. It was indicated Resident R34 went out to an appointment and was placed on antibiotics. RN, Supervisor, Employee E2 stated Resident R34 was on doxycycline for the tracheostomy infection. It was indicated RN Supervisor, Employee E2 and licensed practical nurses provide care to Resident R34's trach. RN, Supervisor, Employee E2 confirmed Resident R34's office visit from [DATE], for the tracheostomy evaluation was not available and was not located in the resident's clinical record. RN, Supervisor Employee E2 stated Resident R34 was sent out to the hospital a few times due to the inability to reinsert the inner cannula. It was indicated the resident is monitored every shift and it should be documented in the Treatment Administration Record (TAR).</p> <p>During a phone interview on [DATE], at 11:47 a.m. with Resident R34's otolaryngology provider's office, it was confirmed Resident R34 was evaluated on [DATE], and had a follow up appointment scheduled for [DATE].</p> <p>Review of Resident R34's clinical record on [DATE], at 11:52 a.m. failed to include an order to follow up with the otolaryngology provider on [DATE]. Review of Resident R34's physician orders failed to include orders for the resident's tracheostomy care, including cleaning, size of inner cannula, suctioning, enhanced barriers, and how often to change the neck ties on the resident's tracheostomy. The facility failed to include orders to monitor/document for restlessness, agitation, confusion, increased heart rate, and bradycardia as the resident's care plan indicated. There were no orders to monitor/document respiratory rate, depth, and quality.</p> <p>Review of 4 of 4 employee files (LPN, Employee E1, RN Supervisor, Employee E2, LPN, Employee E9 and LPN, Employee E11) on [DATE], failed to include evidence they were educated and competent on tracheostomy care.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE], at 1:59 p.m. the Director of Nursing and Nursing Home Administrator confirmed the facility failed to implement interventions for residents with a tracheostomy, ensure residents have orders and care plans for trach care and suctioning, obtain trach cultures as ordered (Resident R34), and ensure staff were competent in tracheostomy care for two of two residents (Resident R32 and R34).</p> <p>Review of the facility assessment on [DATE], at 2:06 p.m. failed to include tracheostomy care.</p> <p>During an interview on [DATE], at 2:08 p.m. the Nursing Home Administrator confirmed tracheostomy care was not listed in the facility assessment.</p> <p>Based on the above findings an Immediate Jeopardy situation was identified to the Nursing Home Administrator and Director of Nursing on [DATE], at 3:47 p.m. for the failure of the facility to provide tracheostomy care to a resident in accordance with professional standards of practice for two of two residents (Resident R32 and R34). This failure resulted in Resident R34 having a complete tracheostomy obstruction and experiencing respiratory and emotional distress. An Immediate Jeopardy template was provided to the Nursing Home Administrator.</p> <p>On [DATE], at 5:41 p.m. the facility submitted a plan of correction. The plan was reviewed and it was rejected. The facility failed to contain a root cause analysis, who was responsible for the POC, how long the facility was to monitor.</p> <p>On [DATE], at 7:19 p.m. the facility's plan of correction was received and accepted which included the following interventions:</p> <p>The facility developed the following approved action plan:</p> <p>A root cause analysis was completed that determined the cause to be inconstant coverage of information in the clinical meetings due to not following a specific checklist that can be followed by other clinical team members when the DON is not able to be at the daily meeting. A specific checklist will be implemented on [DATE].</p> <p>1. Identified Residents</p> <p>-Resident 32 is not in the facility. She will be assessed and reevaluated upon return by the Director of Nursing or designee. R34 baseline care plan was completed on [DATE] by the DON. Order for enhanced barrier precautions obtained by the DON on [DATE]. Order for O2 discontinued for nonuse by the DON on [DATE]. Trach care orders obtained and updated by the DON on [DATE]. Care plan was updated by the MDS Nurse to reflect current status on [DATE].</p> <p>2. Like Residents</p> <p>-House review completed by DON and designee on [DATE].</p> <p>3. System Correction and Education's</p> <p>-The Director of Nursing and Regional Clinical Director reviewed the trach care policy on [DATE]. No updates were needed.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The licensed staff will be educated on the Trach Care Policy by the DON or designees on [DATE].</p> <p>-Nursing will sign education signature sheet prior to their next worked shift, if they completed the Carefeed training. Training for all licensed nurses will be completed on [DATE].</p> <p>-The facility assessment was updated to include trach care was update by the Administrator on [DATE].</p> <p>4. Monitor and Audit</p> <p>-An Ad Hoc QAPI meeting was held by Administer on [DATE].</p> <p>-All new admissions and readmissions will be audited daily in the Clinical Meeting by the DON or designees utilizing a clinical checklist to include trach care, barrier precautions and care plans weekly for 4 weeks beginning on [DATE].</p> <p>On [DATE], at 7:22 p.m. the NHA and DON were notified the facility was still in immediate jeopardy and in order to lift, the facility must provide evidence the plan of correction was implemented. The DON and NHA were notified staff must be interviewed to verify competency.</p> <p>On [DATE], 12:23 p.m. the NHA was asked if information related to the facility's plan of correction was available for review. It was indicated the facility was pulling stuff together.</p> <p>On [DATE], at 2:18 p.m. the Director of Clinical Operations, Employee E24 provided the education that the facility trained all their licensed staff for tracheostomy care.</p> <p>During an interview on [DATE], at 3:03 p.m. the Director of Clinical Operations, Employee E24, NHA, and DON were asked what professional standards of practice or guidance did the facility utilize to educate the facility's licensed nursing staff. It was indicated staff were educated using the policy and competency tool. The policy and competency tool failed to include what to do with the emergency tracheostomy kit, what emergency supplies must be available at the bedside, suctioning, enhanced barriers, physician orders and care plans. The DON stated it is not the facility's policy to have a smaller trach size available for emergencies. The DON stated an Ambu bag is located on the facility's crash cart located in the common area on each nursing unit. The DON indicated training for emergency care for a resident with a tracheostomy is no different than cleaning or changing the inner cannula when placing one in an emergency. All nurses are CPR certified and CPR training covers how to use an Ambu bag.</p> <p>During an interview on [DATE], at 3:30 p.m. the Nursing Home Administrator was asked to provide the education that was sent on care feed.</p> <p>On [DATE], at 3:36 p.m. the education that was provided on care feed was provided by the Director of Clinical Operations, Employee E24.</p> <p>On [DATE], at 3:52 p.m. a review of the documents provided by the facility for the plan of correction failed to include evidence staff were educated on what to do with the emergency tracheostomy kit, what emergency supplies must be available at the bedside, suctioning, enhanced barriers, physician orders and care plans.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE], at 9:15 a.m. Director of Clinical Operations, Employee E24 provided the education that staff were trained on. The education included what to do with the emergency tracheostomy kit, what emergency supplies must be available at the bedside, trach care including, cleaning, suctioning, enhanced barriers, physician orders and care plans.</p> <p>On [DATE], at 9:22 a.m. Director of Regional Clinical Operations indicated the facility was reeducating all licensed nurses. The facility failed to ensure all licensed staff were educated prior to the start of their shift.</p> <p>During an interview and observation completed with Resident R32 on [DATE], at 9:31 am Resident R32 stated I have had a trach since 2016. No one changes my tracheostomy neck ties, I can't do that. The resident's suction machine was observed unplugged, on the side table to the left side of her bed. Resident R32 stated I have to stretch to reach it and they have to plug it in. A yellow/tannish substance was observed in the suction tubing and the cannister. The suction tubing was lying over the machine and was not stored properly in a bag. Resident R32 further stated, I have to pull my table over, change the suction catheter, then staff would have to plug it in. I have waited as long as 45 minutes for them to come in. Upon asking about hand hygiene, she replied I did have hand sanitizer in here, I can't find it. Three 6XL cuffed tracheostomy kits were observed at Resident R32's bedside. Resident R32 stated I am cuffless. Resident R32 stated the extra cannulas (2 in white bag in drawer) and the suction kit (on the overbed table) was provided from the hospital, I like them better. The ones they have here are really long. An expired gallon of distilled water dated [DATE], was observed at the resident's bedside. Resident R32 indicated the water was used for her tracheostomy care. A bag of trach ties was noted on the floor, a basin was on the floor that contained a humidifier bottle that was dated [DATE]. A bag was on the floor next to dresser that had some trach supplies in it.</p> <p>During an interview completed on [DATE], at 9:50 am, Registered Nurse (RN) Employee E2 confirmed the above observations.</p> <p>During an observation and interview on [DATE], at 10:13 a.m. Resident R34 indicated staff do not empty the suction canister, they leave it filled, let it go to the top. Resident R34 indicated suctioning is used daily.</p> <p>During an observation and interview on [DATE], at 10:26 a.m. Resident R34 had a sterile tracheostomy care tray with sterile gloves opened located on the bedside table. Resident R34's personal belongings (stress balls) were observed on top of the opened tracheostomy care tray. Distilled water was observed on the floor. The resident stated the water was used for her tracheostomy care. A used, opened tracheostomy kit with a dirty spoon in it was observed behind Resident R34's television. Pipe cleaners were observed lying on the resident's tv stand without a bag. The resident's suction catheter tubing was unbagged lying on the bedside dresser. A 7.5 inner cannula was observed in the resident's top drawer in her dresser and a 5.00 disposable inner cannula was observed under the resident's tv on the dresser. There was oxygen tubing, not store in a bag, located behind the resident's tv. There were no emergency supplies, including ambu bag, obturator, or one size smaller inner cannula at the resident's bedside.</p> <p>During an interview on [DATE], at 10:52 a.m. RN, Supervisor, Employee E2 confirmed the above observations.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident R34's clinical record on [DATE], at 11:20 a.m. revealed the facility failed to enter an order to change Resident R34's inner cannula and neck ties and include the size of the resident's inner cannula. Resident R34's care plan was not updated, last revised [DATE], and failed to include how often to change/clean the inner cannula and the size of the resident's tracheostomy.</p> <p>During an observation on [DATE], 12:05 p.m. the crash cart located on 4th floor the following was observed.</p> <ul style="list-style-type: none"> -The cart was unlocked -Oxygen tank failed to have regulator attached (as the checklist located on top of the cart indicated) -No tubing or Yanker connected to suction canister (as the checklist located on top of the cart indicated) -An expired 250 ml 0.9% Normal Saline Solution IV fluid bag (expired ,d+[DATE]) -Dressing kit tray expired [DATE] <p>During an interview on [DATE], at 12:20 p.m. the DON confirmed the above findings.</p> <p>During interviews completed on [DATE], from 1:30 p.m. until 1:40 p.m. 4 of 4 licensed nurses failed to confirm they were educated on trach care, emergency care, how to obtain a trach culture, and how long to suction.</p> <p>During review of clinical records on [DATE], at 2:06 p.m. 2 of 2 residents failed to have an order for their inner cannula size, how often to clean/change the inner cannula and neck ties. 2 of 2 care plans failed to be individualized and have information related to how often trach care is performed (cleaning/changing inner cannula and neck ties) and the size of the resident's inner cannula. (Resident R32 and R34). The facility failed to implement their plan of correction.</p> <p>During an interview on [DATE], at 3:19 p.m. the Nursing Home Administrator and DON were notified the facility failed to implement their plan of correction.</p> <p>On [DATE], at 9:45 a.m. the NHA was asked if the facility was ready to verify education competency and if it was okay to re-interview staff. The NHA stated give us a minute and the DON said he already talked with staff.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE], at 10:02 a.m. LPN, Employee E1 was interviewed to verify competency of the education the facility provided on Trach Care, Enhanced Barrier Precautions, and Care Plans. LPN, Employee E1 had the education provided by the facility available in front of him. LPN, Employee E1 failed to know what emergency supplies are readily available at the bedside. When asked what size inner cannulas should be available, LPN, Employee E1 stated 5, 7, 9 then stated Let me cheat for that one and then looked through the education provided from the facility and stated pretty sure size 5, 7, and 9. LPN, Employee E1 failed to indicate the size of the resident's inner cannula and a size smaller. LPN, Employee E1 asked what is an obturator? When asked what would you do if you were unable to reinsert trach tube if smaller cannula does is unsuccessful, LPN, Employee E1 stated Call, 911. and failed to know to cover the resident's stoma with sterile gauze and use a bag-valve mask over mouth and nose as the education provided by the facility revealed. LPN, Employee E1 failed to know how to obtain to culture of the tracheostomy and indicated a culture swab would be used to obtain it from the resident's inner cannula. The facility's education indicated a trach culture is obtained by using a suction catheter, then suctioning the airway secretions into a sterile container, then labeling the specimen with the resident info, date and time. The culture is then sent to the lab immediately.</p> <p>Review of Resident R34's clinical record on [DATE], at 10:40 a.m. failed to include an updated personalized care plan with interventions related trach care. Resident R34's care plan was not updated, last revised [DATE], and failed to include how often to change/clean the inner cannula and the size of the resident's tracheostomy. The facility failed have care plans for tracheostomy updated by the MDS Nurse to reflect current status on [DATE], as the facility plan of correction indicated.</p> <p>On [DATE], at 1:13 p.m. review of Resident R32 's clinical record revealed the resident returned to the facility on [DATE]. Orders and care plans were reviewed and updated to include individualized care for the resident's tracheostomy. Resident R34 's orders for trach care with size of trach tubes, emergency care, and suctioning were entered on [DATE]. The resident 's care plan was updated on [DATE], to include personalized center care for trach care, including size and suctioning. No other residents currently in-house were in need of trach care.</p> <p>On [DATE], at 1:22 p.m. review of the summary sheet provided for the electronic training (Carefeed) revealed 19 of 19 licensed nursing staff were educated. During in-person interviews conducted on [DATE], three of three licensed nursing staff members confirmed they were educated on trach care, suctioning, and what to do in an emergency, and how to obtain a trach culture. During phone interviews completed on [DATE], two of eight licensed nursing staff answered the phone and confirmed they were educated on trach care, suctioning, what to do in an emergency, and how to obtain a culture.</p> <p>Review of the facility assessment on [DATE], revealed it was updated to include trach care by the Administrator on [DATE].</p> <p>An audit was completed by the DON on [DATE]. No new residents w [TRUNCATED]</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785</p> <p>Based on review of facility policy, clinical record, and staff interviews, it was determined that the facility failed to maintain a complete record of pre and post dialysis assessments for three out of five sampled resident records (Resident R20, R38, and R233).</p> <p>Findings include:</p> <p>The facility Hemodialysis care policy 9/18/24, indicated that hemodialysis (a treatment for advanced kidney failure that filters wastes, salts, and fluid from your blood) devices may only be accessed by personnel who have received training and demonstrated clinical competency.</p> <p>Review of Resident R20's clinical record revealed, the resident was admitted to the facility on [DATE], with diagnoses of dependence on renal dialysis (acts like an artificial kidney, removes waste and fluid from the body), end stage renal disease (the final stage of chronic kidney disease where the kidney can no longer filter waste and excess fluids from the blood effectively), and heart failure (a condition where the heart muscle doesn't pump blood as well as it should).</p> <p>Review of Resident R20's care plan 2/5/25, indicated the resident needs dialysis due to renal failure. Interventions included to encourage the resident to go to scheduled dialysis appointments on Tuesday, Thursday, and Saturday.</p> <p>Review of Resident R20's physician order dated 2/7/25, indicated the resident is scheduled to have dialysis three times a week on Tuesday, Thursday, and Saturday. The facility failed to timely enter Resident R20's order for dialysis.</p> <p>Review of Resident R20's progress note dated 2/8/24, at 7:27 p.m. stated the resident missed dialysis on Thursday and today.</p> <p>Review of Resident R20's progress note dated 2/8/25, at 7:37 p.m. revealed the physician was notified the resident missed dialysis on Thursday and Saturday. The physician ordered to send the resident out to the hospital for dialysis. Recommendations included to send patient to dialysis on dialysis days.</p> <p>Review of Resident 20's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/10/25, indicated diagnoses were current.</p> <p>Review of Resident R20's Emergency Department Evaluation report dated 2/8/25, revealed the resident was presenting to the emergency room due to missed dialysis. The plan was to obtain screening labs, EKG, and assess for any emergent dialysis, and return to the skilled nursing facility and have outpatient dialysis.</p> <p>Review of Resident R20's Hospital Discharge Summary dated 2/8/25, revealed at 9:09 p.m. the resident had a critical venous oxyhaemoglobin level (percentage of hemoglobin that is bound to oxygen) of 21 (Reference range: 70-80).</p> <p>(continued on next page)</p>		

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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.			
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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R20's progress note dated 2/9/25, at 5:10 a.m. revealed the resident returned to the facility with no new orders.</p> <p>Review of facility documents dated on 4/4/25, dated 2/6/25, and 2/8/25, failed to reveal Resident R20 went on a leave of absence to dialysis on 2/6/25, and 2/8/25, as ordered.</p> <p>Review of Resident R20's dialysis communication binder on 4/4/25, at 1:00 p.m. failed to include any completed dialysis communication forms.</p> <p>During an interview on 4/4/25, at 10:53 a.m. the DON was asked who is responsible for entering physician orders and stated it is the responsibility of the RN Supervisor.</p> <p>During an interview on 4/4/25, at 1:11 p.m. Registered Nurse, Employee E2 stated the RN Supervisor is responsible for scheduling resident appointments, coordinating with providers, entering admission orders, completing daily assessments forms, assist the nurses on the cart, and to respond to resident's change in condition. RN Supervisor, Employee E2 confirmed Resident R20's order for dialysis was not entered timely.</p> <p>During an interview on 4/4/25, at 1:57 p.m. the Nursing Home Administrator confirmed the facility failed to ensure Resident R20 received dialysis as ordered.</p> <p>Review of Resident R38's admission record indicated he was originally admitted [DATE].</p> <p>Review of Resident R38's MDS assessment (MDS: Minimum Data Set assessment-a periodic assessment of resident care needs) dated 9/4/24, indicated he had diagnoses that included Post traumatic stress disorder (PTSD: a mental and behavioral disorder that develops related to a terrifying event), chronic kidney disease (a loss of kidney function resulting in the swelling of feet, fatigue, high blood pressure and changes in urination), and repeated falls. The diagnoses were the most recent upon review.</p> <p>Review of Resident R38's care plans dated 3/12/25, indicated that Resident R38 needs hemodialysis, his dialysis is schedule Tuesday, Thursday and Saturday, and he will not signs of any complications from dialysis.</p> <p>Review of Resident R38's physician order dated 3/27/25, indicated to obtain vitals pre and post dialysis visits on Tuesday, Thursday and Saturday.</p> <p>Review of Resident R38's clinical nurse notes, certified nurse practitioner documents, and dialysis communication forms indicated no updated dialysis communication forms since 8/15/24.</p> <p>During an interview on 4/2/25, at 11:06 a.m. the Director of Nursing (DON) confirmed that the facility failed to maintain a complete record of pre and post dialysis assessments for Resident R38 as required.</p> <p>Review of Resident R233's clinical record revealed, the resident was admitted to the facility on [DATE], with diagnoses of dependence on renal dialysis, end stage renal disease, and adult failure to thrive.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R233's progress note dated 3/25/25, revealed the resident was admitted to the facility and had a central catheter present in the left jugular area for dialysis.</p> <p>Review of Resident R233's care plan dated 3/27/25, revealed the resident required hemodialysis due to renal failure. Interventions included to monitor/document/report as needed any signs and symptoms of infection to access site such as redness, swelling, warmth, or drainage.</p> <p>During an observation on 3/31/25, at 9:54 a.m. Resident R233 was observed lying in bed and his right upper chest tesio port (a type of central venous catheter specifically designed for hemodialysis access) was observed uncovered, open to air, with no dressing.</p> <p>During an interview on 3/31/25, at 9:55 a.m. LPN, Employee E1 confirmed Resident R233 central line failed to have a dressing. LPN, Employee E1 stated Infection Preventionist, Employee E8 was in Resident R233's room earlier.</p> <p>Review of Resident R233's physician orders dated 3/31/25, indicated the resident attends dialysis every Tuesday, Thursday, and Saturday. The order for dialysis was entered four days after the resident was admitted to the facility. The facility failed to timely enter an order for Resident R233's dialysis.</p> <p>During an interview on 3/31/25, at 2:07 p.m. the Nursing Home Administrator and Director of Nursing confirmed the facility failed to provide dialysis care and services to meet the needs of Resident R233.</p> <p>During an observation on 4/4/25, at 12:42 p.m. Resident R233's dialysis communication binder failed to have any completed communication sheets.</p> <p>During an observation 4/4/25, at 12:39 p.m. a letter from the resident's dialysis center dated 12/3/24, was reviewed that stated In order to ensure we are providing the best possible care for our patients, we need to know our patient's vaccination status. Please let us know if the following residents have received their influenza vaccine or declined it: Resident R38 and R233.</p> <p>During a phone interview on 4/4/25, at 12:47 p.m. Dialysis Registered Nurse, Employee E26 confirmed the facility failed to coordinate care for Resident R233. The facility failed to provide Resident R233's influenza vaccination status. When asked if resident's with tesio ports need a dressing covered at all times, Dialysis RN, Employee E26 stated most definitely.</p> <p>During an interview on 4/4/25, at 1:03 p.m. the Nursing Home Administrator and DON confirmed the facility failed to ensure residents who require dialysis treatment receive such services, timely and consistent with professional standards of practice, and maintain an ongoing communication and assessment of the resident's condition and monitoring for complications before, during, and after dialysis treatments for two of four dialysis resident's reviewed (Resident R20, R38 and R233).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18 (b)(1)(e)(1) Management.</p> <p>28 Pa. Code: 211.10(d) Resident care policies.</p> <p>(continued on next page)</p>		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code: 211.12 (d)(1)(5) Nursing services.

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785</p> <p>Based on review of facility policy, resident record review, and staff interview, it was determined that the facility failed to develop care plans with identified triggers for residents with the diagnosis of Post Traumatic Stress Disorder (PTSD - a mental and behavioral disorder that develops related to a terrifying event) to prevent re-traumatization for three of three sampled residents (Resident R33, R38, and R42).</p> <p>Findings include:</p> <p>The facility Trauma informed care policy dated [DATE], indicated all staff are provided in-services about trauma and trauma informed care. Trauma results from an event, series of events, or circumstance that is experienced by an individual and has lasting adverse effects. A trigger is a stimulus that prompts recall of a previous traumatic event. Care plans that address past trauma identify and decrease exposure to triggers.</p> <p>Review of Resident R33's admission record indicated she was admitted on [DATE].</p> <p>Review of Resident R33's MDS assessment (MDS: Minimum Data Set assessment-a periodic assessment of resident care needs) dated [DATE], indicate the diagnosis of hypertension (high blood pressure), cerebrovascular accident (CVA-stroke blood flow to part of brain is stopped), and non-Alzheimer's dementia (memory impairment).</p> <p>Review of Resident R33's care plan dated [DATE] indicated I experienced a traumatic event in my life as evidenced by the assessment for adults (TAA) /PTSD. The traumatic event I experienced was: Parents died within months of each other when she was 10. Grandma was caregiver, then passed. Went to live with Aunt and was sexually molested. (Information given by daughter, she said her mother will be very upset if anyone tries to talk to her about this, just wanted us to be aware, in case any behaviors/anxiety).</p> <p>Review of Resident R32's care plans did not include triggers related to post-traumatic stress disorder.</p> <p>During an interview completed on [DATE], at 11:45 a.m. Social Service Employee E10 confirmed that Resident R32's care plan did not include triggers related to post-traumatic stress disorder.</p> <p>Review of Resident R38's admission record indicated he was originally admitted [DATE].</p> <p>Review of Resident R38's MDS assessment dated [DATE], indicated he had diagnoses that included Post-Traumatic Stress Disorder (PTSD - a mental and behavioral disorder that develops related to a terrifying event), chronic kidney disease (a loss of kidney function resulting in the swelling of feet, fatigue, high blood pressure and changes in urination), and repeated falls. The diagnoses were the most recent upon review.</p> <p>(continued on next page)</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R38's care plans dated [DATE], indicated that Resident R38 experienced a traumatic event in his life as evidenced by a trauma assessment. The traumatic event was a life-threatening illness.</p> <p>Review of Resident R38's care plans did not include triggers related to post-traumatic stress disorder.</p> <p>During an interview on [DATE], at 11:06 a.m. the Director of Nursing (DON) confirmed that the facility failed to develop care plan for resident with PTSD and document identified behavioral triggers that may cause re-traumatization for Resident R38.</p> <p>Review of R42's admission record indicated she was originally admitted [DATE].</p> <p>Review of Resident R42's MDS assessment dated [DATE], indicate the diagnosis of Post-Traumatic Stress Disorder (PTSD - a mental and behavioral disorder that develops related to a terrifying event), diabetes (high sugar in the blood) and anemia (low iron in the blood)</p> <p>Review of Resident R42's care plans did not include a focus or triggers related to post-traumatic stress disorder</p> <p>During an interview completed on [DATE], at 11:25 a.m. the Director on Nursing (DON) confirmed that the facility failed to develop a care plan for resident R42 and that the facility failed to develop care plans with identified triggers for residents with the diagnosis of Post Traumatic Stress Disorder (PTSD - a mental and behavioral disorder that develops related to a terrifying event) to prevent re-traumatization for three of three sampled residents (Resident R33, R38, and R42).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</p> <p>Based on review of facility policy, resident observations, resident and staff interviews, and grievance review, it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of two of two residents (Residents R20 and R77).</p> <p>Findings Include:</p> <p>The job description for the Nursing Home Administrator dated 10/29/24, specified the primary purpose of the job is to manage the facility in accordance with current applicable, federal, state, and local standards, guidelines, and regulations the govern long-term care facilities. It is the NHA job to follow all facility policies and to ensure the highest degree of quality care is provided to the residents at all times.</p> <p>The job description for the Director of Nursing dated 9/16/24, specified it is the responsibility of the DON to organize, develop, and direct the overall operations of the Nursing Service Department in accordance with current federal, state and local standards, guidelines and regulations that govern the facility.</p> <p>Review of Resident R20's clinical record revealed, the resident was admitted to the facility on [DATE], with diagnoses of dependence on renal dialysis (acts like an artificial kidney, removes waste and fluid from the body), end stage renal disease (the final stage of chronic kidney disease where the kidney can no longer filter waste and excess fluids from the blood effectively), and heart failure (a condition where the heart muscle doesn't pump blood as well as it should).</p> <p>Review of Resident R20's care plan 2/5/25, indicated the resident needs dialysis due to renal failure. Interventions included to encourage the resident to go to scheduled dialysis appointments on Tuesday, Thursday, and Saturday.</p> <p>Review of Resident R20's physician order dated 2/7/25, indicated the resident is scheduled to have dialysis three times a week on Tuesday, Thursday, and Saturday. The facility failed to timely enter Resident R20's order for dialysis.</p> <p>Review of Resident R20's progress note dated 2/8/24, at 7:27 p.m. stated the resident missed dialysis on Thursday and today.</p> <p>Review of Resident R20's progress note dated 2/8/25, at 7:37 p.m. revealed the physician was notified the resident missed dialysis on Thursday and Saturday. The physician ordered to send the resident out to the hospital for dialysis. Recommendations included to send patient to dialysis on dialysis days.</p> <p>Review of Resident 20's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/10/25, indicated diagnoses were current.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R20's Emergency Department Evaluation report dated 2/8/25, revealed the resident was presenting to the emergency room due to missed dialysis. The plan was to obtain screening labs, EKG, and assess for any emergent dialysis, and return to the skilled nursing facility and have outpatient dialysis.</p> <p>Review of Resident R20's Hospital Discharge Summary dated 2/8/25, revealed at 9:09 p.m. the resident had a critical venous oxyhaemoglobin level (percentage of haemoglobin that is bound to oxygen) of 21 (Reference range: 70-80).</p> <p>Review of Resident R20's progress note dated 2/9/25, at 5:10 a.m. revealed the resident returned to the facility with no new orders.</p> <p>Review of facility documents dated on 4/4/25, dated 2/6/25, and 2/8/25, failed to reveal Resident R20 went on a leave of absence to dialysis on 2/6/25, and 2/8/25, as ordered.</p> <p>Review of the clinical record indicated Resident R77 was admitted to the facility on [DATE], with diagnoses of respiratory failure, immunodeficiency, and kidney transplant rejection.</p> <p>Review of Resident R77's Hospital Discharge Summary dated 3/3/25, indicated to follow up with the resident's transplant surgery office within three weeks. Call to schedule follow up appointment.</p> <p>Review of Resident R77's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/7/25, indicated diagnoses were current.</p> <p>Review of Resident R77's clinical record on 4/1/25, at 11:44 a.m. failed to include a physician order or evidence Resident R77 followed up with the transplant surgery office as ordered.</p> <p>During an interview on 3/31/25, at 9:55 a.m. Licensed Practical Nurse, Employee E1 indicated it was their first day on the job.</p> <p>During an interview on 4/1/25, at 11:50 a.m. Registered Nurse Supervisor, Employee E2 confirmed Resident R77's appointment was not scheduled. RN Supervisor, Employee E2 The RN Supervisor is responsible for all appointments, what happens is it is delayed due to staffing.</p> <p>During an interview on 4/1/25, at 11:53 a.m. Licensed Practical Nurse, Employee E1 revealed it was their second day working in the facility. The first day their assignment was on the second floor and today it was on the fourth floor. LPN, Employee E1 confirmed they were not assigned a preceptor or mentor.</p> <p>During an observation and interview on 4/2/25, at 10:25 a.m. RN Supervisor, Employee E2 was observed on a medication cart, passing medications. RN, Supervisor, Employee E2 confirmed they were the RN Supervisor.</p> <p>During an interview on 4/4/25, at 10:53 a.m. the DON was asked who is responsible for entering physician orders and stated it is the responsibility of the RN Supervisor.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview and observation on 4/4/25, at 12:32 p.m. RN Supervisor was observed passing medications and was asked if she was still functioning as RN Supervisor. RN Supervisor, Employee E2 responded yes and stated It didn't last that long, all good things must come to an end.</p> <p>During an interview on 4/4/25, at 1:11 p.m. RN Supervisor, Employee E2 stated the RN Supervisor is responsible for scheduling appointments, coordinating with the providers, completing admission and discharge paperwork, performing daily assessments, assessing resident's change in condition, notifying the family and physician, and assist with medication administrations when needed. The Director of Nursing was asked if the facility has a concern for sufficient staffing and responded no. The DON stated the facility has nurses call off two to three times a week. It was confirmed the facility does not utilize agency nurses.</p> <p>During an interview on 4/4/25, at 1:30 p.m. RN Supervisor, Employee E2 stated the reason for staffing issue is not call offs, it's because no one is scheduled, there is not enough staff.</p> <p>Review of the facility's projected daily staffing sheet for 4/5/25, on 4/4/25, at 2:00 p.m. failed to include any Licensed Practical Nurses scheduled to work on the 2nd floor. The only nurse assigned to the second floor was the RN supervisor.</p> <p>Review of the facility's daily staffing sheet dated 4/5/25, revealed the Director of Nursing was the RN supervisor.</p> <p>During an interview on 4/5/25, at 4:45 p.m. the Director of Nursing and Nursing Home Administrator confirmed that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of two of two residents. (Residents R20 and R77).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(e)(6) Management.</p> <p>28 Pa. Code: 201.20(a) Staff development.</p> <p>28 Pa. Code: 211.12(c)(d)(1)(2)(3)(4) Nursing services.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>46337</p> <p>Based on review of facility policy, Nursing staff personnel records, nurse training documentation and staff interview, it was determined that the facility failed to ensure the facility had sufficient nursing staff with the appropriate competencies and skills sets to provide tracheostomy care for four of four staff members (Licensed Practical Nurse, Employee E1, Registered Nurse Supervisor E2, LPN, Employee E9 and LPN, Employee E11).</p> <p>Findings include:</p> <p>During an interview on 3/31/25, at 11:26 a.m. LPN, Employee E1 was asked if they were trained on tracheostomy care. LPN, Employee E1 indicated it was their first day and the facility did not train or educate LPN, Employee E1 on tracheostomy care. LPN, Employee E1 confirmed they were assigned to Resident R34 and indicated they had experience in pediatric trach care.</p> <p>Review of 4 of 4 employee files (LPN, Employee E1, RN Supervisor, Employee E2, LPN, Employee E9 and LPN, Employee E11) on 3/31/25, failed to include evidence they were educated and competent on tracheostomy care.</p> <p>Review of the facility assessment on 3/31/25, at 2:06 p.m. failed to include tracheostomy care.</p> <p>During an interview on 3/31/25, at 2:08 p.m. the Nursing Home Administrator confirmed tracheostomy care was not listed in the facility assessment and the facility provides care for two of two residents who require tracheostomy care (Residents R32 and R34).</p> <p>During an interview on 3/31/24, at 1:59 p.m. the Director of Nursing and Nursing Home Administrator confirmed that the facility failed to ensure the facility had sufficient nursing staff with the appropriate competencies and skills sets to provide tracheostomy care for four of four staff members (Licensed Practical Nurse, Employee E1, Registered Nurse Supervisor E2, LPN, Employee E9 and LPN, Employee E11).</p> <p>28 Pa Code: 201.14(a) Responsibility of licensee</p> <p>28 Pa Code:201.18(b)(1) Management</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>49469</p> <p>Based on review of facility policy, personnel records, and staff interview it was determined that the facility failed to complete annual performance evaluations for three out of five nurse aides (NA) (NA Employee E26, E27, and E29).</p> <p>Findings include:</p> <p>Review of nurse aide performance evaluations completed by the facility failed to include a performance evaluation for Nurse Aide Employee E26, with a hire date of 8/21/07.</p> <p>Review of nurse aide performance evaluations completed by the facility failed to include a performance evaluation for Nurse Aide Employee E27, with a hire date of 11/1/19.</p> <p>Review of nurse aide performance evaluations completed by the facility failed to include a performance evaluation for Nurse Aide Employee E29, with a hire date of 7/19/22.</p> <p>During an interview 4/4/25, at 2:30 p.m. Human Resource (HR) Employee E30 confirmed that the facility failed to complete annual performance evaluations for three of five nurse aides as required.</p> <p>28 Pa Code: 201.20 (a)(b)(d) Staff development.</p> <p>28 Pa Code: 201.14 (a) Responsibility of licensee.</p>		

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NAME OF PROVIDER OR SUPPLIER Burgh Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 909 West Street Pittsburgh, PA 15221	
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27424</p> <p>Based on review of facility documentation, clinical records and staff interview it was determined that the facility failed to correctly label medication for two of four residents (Resident R2 and Resident R17) and failed to implement pharmaceutical services to ensure accurate provision of medications for two of four residents (Resident R4 and Resident R77).</p> <p>Findings include:</p> <p>Review of the facility policy, Medication Regimen Review dated 9/18/24, indicated the Medication Regimen Review (MRR) or Drug Regimen Review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimize adverse consequences and potential risks associated with medication. The MRR includes a review of the medical record in order to prevent, identify, report, and resolve medication related problems, medication errors, or other irregularities.</p> <p>Review of facility policy, Emergency Drug Services dated 9/18/24, indicated Pharmacy will provide any prescriptions and supplies requested by the facility for patients on an emergency basis or stat (statim) basis. This emergency service will be provided twenty - four (24) hours per day, seven (7) days per week. In the event Pharmacy cannot timely furnish an ordered medication due to circumstances beyond their control, Pharmacy will make arrangements with another pharmacy to provide Pharmacy product to a facility.</p> <p>During a medication room observation completed on 4/5/25, at 10:47 a.m. the fourth-floor medication room it was discovered that the medication refrigerator contained 2 unbagged Lantus insulin pens, the pens were identified as belonging to resident R2 and R17, further observation revealed that both pens were labeled with the incorrect names. The residents last names were misspelled and labeled using the second letter of the residents ' last name.</p> <p>During an interview completed on 4/4/25, at 10:29 a.m. Licensed Practical Nurse (LPN) Employee E25 confirmed that the insulin pens were labeled with misspelled last names.</p> <p>During an interview on 4/4/25, at 10:56 a.m. the Director of Nursing (DON) confirmed that the facility failed to implement pharmaceutical services to ensure accurate provision of medications for four of four residents.</p> <p>Resident R4 was admitted to the facility on [DATE].</p> <p>Review of Resident R4 MDS (minimum data set - a periodic assessment of resident needs) dated 2/26/25, had diagnosis of atrial fibrillation (irregular and often very rapid heart rhythm), neoplasm of breast (kind of breast cancer that begins in the cells of of the breast tissue) and osteoarthritis (joint disease in which tissues break down over time).</p> <p>Review of Resident R4 physician orders indicated:</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2/25/2025 21:18 Orders - Administration Note</p> <p>Note Text: Lidocaine Viscous HCl Mouth/Throat Solution 2 %</p> <p>Give 100 ml by mouth before meals and at bedtime for oral pain awaiting delivery</p> <p>2/25/2025 16:10 Orders - Administration Note</p> <p>Note Text: Kool 'N Fit Spray (Camphor/Menthol/Methyl Salicylate)</p> <p>Apply to bil shoulders topically two times a day for pain not being filled by pharmacy</p> <p>During an interview on 4/5/25, at 12: 12 p.m. DON confirmed that the facility failed to implement pharmaceutical services to ensure accurate provision of medication for Resident R4.</p> <p>Resident R77 was admitted to the facility on [DATE].</p> <p>Resident R77 MDS dated [DATE], with diagnosis of Acute Respiratory Failure with hypoxia (not enough oxygen in blood), and kidney transplant rejection (body doesn't accept the new kidney and fights against it).</p> <p>Review of Resident R77 clinical record physician orders indicated:</p> <p>Repatha</p> <p>Subcutaneous</p> <p>Solution Prefilled</p> <p>Syringe 140 MG/ML</p> <p>(Evolocumab)</p> <p>Inject 1 ml</p> <p>subcutaneously in</p> <p>the morning every</p> <p>14 day(s) for HLD</p> <p>-Start Date03/10/2025 0800</p> <p>-D/C Date03/19/2025 1904</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Biotin Forte Oral</p> <p>Tablet 5 MG (Biotin)</p> <p>Give 2 tablet by</p> <p>mouth one time a</p> <p>day for Supplement</p> <p>-Start Date03/04/2025 1400</p> <p>-D/C Date03/19/2025 1904</p> <p>During an interview on 4/1/25, at 11:50 a.m. Registered Nurse Employee E2 confirmed that Repatha Subcutaneous Solution Prefilled Syringe and Biotin Forte Oral were not given as ordered and the facility failed to implement pharmaceutical services to ensure accurate provision of medications.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code 211.9 (a)(1)(k)(l)(1)(2)(3)(4) Pharmacy services</p> <p>28 Pa. Code 211.10 (c) Resident care policies.</p> <p>28 Pa. Code 211.12 (d)(1)(5) Nursing services.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785</p> <p>Based on review of the pharmacy recommendations, clinical record, and staff interview, it was determined that the facility failed to act on the pharmacy medication recommendations in a timely manner for one of five sampled residents (Resident R38).</p> <p>Findings include:</p> <p>The facility Medication regimen review policy dated 9/14/24, indicated that the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.</p> <p>Review of Resident R38's admission record indicated he was originally admitted [DATE].</p> <p>Review of Resident R38's MDS assessment (MDS: Minimum Data Set assessment-a periodic assessment of resident care needs) dated 9/4/24, indicated he had diagnoses that included Post-Traumatic Stress Disorder (PTSD - a mental and behavioral disorder that develops related to a terrifying event), chronic kidney disease (a loss of kidney function resulting in the swelling of feet, fatigue, high blood pressure and changes in urination), and repeated falls. The diagnoses were the most recent upon review.</p> <p>Review of Resident R38's care plans dated 9/16/24, indicated to administer medications as ordered.</p> <p>Review of Resident R38's physician orders dated 12/24/24, indicated to administer two tablets of Melatonin 5mg by mouth for insomnia as needed.</p> <p>Review of Resident R38's pharmacy medication regimen review (MRR) dated 1/10/25 requested clarification for Melatonin order. Melatonin order has as needed and does not include a frequency of administration (once a day , twice a day, three times a day). Resident R38's Physician signed the MRR/pharmacy recommendation on 1/15/25, stating to add frequency of administration.</p> <p>Review of Resident R38's Melatonin medication order dated 12/24/24 indicated it was still active and was not modified to include the frequency of administration.</p> <p>During an interview on 4/4/25, at 3:20 p.m. information was disseminated to the Nursing Home Administrator (NHA), Director of Nursing (DON), and the Director of Clinical Operations Employee E24 that the facility failed to act on the pharmacy medication recommendations in a timely manner for Resident R38 as required.</p> <p>28 Pa.Code: 211.12(d)(1)(3)(5) Nursing services.</p>		

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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>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</p> <p>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 from significant medication errors for two of six residents (R6 and R77).</p> <p>Findings:</p> <p>Review of facility policy Administering Medications dated 2/12/25, indicated medications are administered in accordance with prescriber order, including any required time frame.</p> <p>Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of Influenza A, hypoxemia (abnormally low levels of oxygen in the blood), and sleep apnea (a sleep disorder where breathing is interrupted repeatedly during sleep characterized by loud snoring and episodes of stop breathing).</p> <p>Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/7/25, indicated diagnoses were current.</p> <p>Review of Resident R6's physician order dated 2/1/25, indicated starting on 2/3/25, to administer one capsule on Tamiflu one time a day every Monday ,Wednesday, and Friday until 2/7/25.</p> <p>Review of Resident R6's progress note dated 2/3/25, indicated the resident's Tamiflu was not available from pharmacy and the medication was discontinued.</p> <p>During an interview on 4/4/25, at 11:22 a.m. the Director of Nursing and Nursing Home Administrator confirmed the facility failed to provide Resident R6's Tamiflu as ordered.</p> <p>Review of the clinical record indicated Resident R77 was admitted to the facility on [DATE], with diagnoses of respiratory failure, immunodeficiency, and kidney transplant rejection.</p> <p>Review of Resident R77's Hospital Discharge Summary dated 3/3/25, indicated to administer 125 milligrams (mg) cyclosporine (immunosuppressive agent used to treat organ rejection post-transplant), one capsule by mouth every 12 hours.</p> <p>Review of a physician order dated 3/4/25, until 3/19/25, indicated to administer 100 mg cyclosporine, one capsule by mouth two times a day for supplement. The facility failed to ensure Resident R77 received 125 mg cyclosporine as order as ordered for a total of 14 days.</p> <p>Review of Resident R77's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/7/25, indicated diagnoses were current.</p> <p>During an interview on 4/1/25, at 11:50 a.m. Registered Nurse Supervisor, Employee E2 confirmed Resident R77 did not receive cyclosporine as ordered from 3/10/25, through 3/18/25. RN, Supervisor Employee E2 stated whoever enters the orders upon admission is responsible for entering them in correctly.</p> <p>(continued on next page)</p>		

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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>During an interview on 4/5/25, at 4:45 p.m. the Director of Nursing and Nursing Home Administrator confirmed the facility failed to make certain that residents are free from significant medication errors for two of six residents (Resident R6 and R77).</p> <p>28 Pa. Code 201.4(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(e)(1)Management</p>		

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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>49469</p> <p>Based on review of facility policy, observations and staff interview it was determined that the facility failed to properly store medical supplies and biologicals in one of four medication carts (4th floor north hall medication cart) and one of two medication rooms (4th floor medication room).</p> <p>Findings include:</p> <p>A review of the facility policy Storage of Medications last reviewed 9/18/24, indicates the facility stores all drugs and biologicals in a safe, secure and orderly manner.</p> <p>A review of the facility policy Administering Medications last reviewed 9/18/24, indicated when opening a multi-dose container, the date opened is recorded on the container.</p> <p>During an observation on 4/4/25, at 9:44 a.m. of the 4th floor North medication cart contained the following:</p> <ul style="list-style-type: none"> . 1 tube zinc oxide . 1 box lidocaine patches . 1 tube skin protectant . 1 60 cc flush piston with the expiration date of 8/2/.24 <p>During an observation on 4/4/25, at 9:56 a.m. the 4th floor Medication room contained the following:</p> <ul style="list-style-type: none"> . A box containing four opened wound vac kits. <p>The area under the sink contained:</p> <ul style="list-style-type: none"> . A Box of opened gloves . An Air compressor . A bag of depends . A giant eagle bag that contained a can of coffee <p>The medication room refrigerator contained:</p> <ul style="list-style-type: none"> . 1 bags vancomycin labeled do not use beyond 2/3/25. <p>(continued on next page)</p>		

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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>. 1 bags vancomycin labeled do not use beyond 2/5/25.</p> <p>. 1 tubersol vial opened and not dated</p> <p>. 1 novolog flex pen in fridge not stored in a bag.</p> <p>. 2 lantus insulin pens in fridge not stored in a bag</p> <p>During an interview completed on 4/4/25, at 10:29 a.m. Licensed Practical Nurse (LPN) Employee E25 confirmed the above observations.</p> <p>During an interview completed on 4/4/25, at 10:56 a.m. the Director of Nursing confirmed that the facility failed to properly store medical supplies and biologicals in one of four medication carts (4th floor north hall medication cart) and one of two medication rooms (4th floor medication room).</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>28 Pa. Code: 211.10(c) Resident care policies.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>35785</p> <p>Based on a review of facility policies, four week cycle menu, and staff interviews it was determined that the facility failed to have a Registered Dietitian review and approve the four week cycle menu and nutritional substitutes prior to implementation for ten out of ten months (June 2024 to December 2024; January 2025 to March 2025).</p> <p>Findings include:</p> <p>The facility Food and nutritional services policy last reviewed 9/18/24, indicated each resident is provided with a nourishing, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>Review of the facility four week cycle menu and nutritional substitutes did not include a signed review from June 2024 to March 2025 by Registered Dietitian Employee E7.</p> <p>During an interview on 4/1/25, at 1:41 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to have a Registered Dietitian review and approve the three week cycle menu and nutritional substitutes prior to implementation from June 2024 to March 2025 as required.</p> <p>28 Pa Code: 211.6(a) Dietary services.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>35785</p> <p>Based on review of facility policy, meal tray observations, staff and resident interviews, it was determined that the facility failed to provide menu selections according to the resident's preference for one of seven sampled residents (Resident R56).</p> <p>Findings include:</p> <p>The facility Food and nutritional services policy last reviewed 9/18/24, indicated that reasonable efforts will be made to accomodate residents' choices and preferences.</p> <p>During meal tray observations on 4/2/25, at 11:27 a.m. Second floor observations of first meal cart was being passed and lunch included the following: chicken a la king, peas, chilled peaches, a biscuit, coffee/juice.</p> <p>During meal tray observations on 4/2/25, at 11:36 a.m. Resident R56 lunch tray was observed with a single portion of protein. Resident R56 lunch ticket read to provide Double portion.</p> <p>During an interview on 4/2/25, at . 11:37 a.m. Resident R56 stated: the double portion is missing.</p> <p>During an interview on 4/2/25, at 12:41 p.m. information disseminated to Nursing Home Administrator (NHA) that the facility failed to provide menu selections according to the resident's preference for Resident R56.</p> <p>28 Pa Code: 211.6(a) Dietary service.</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>35785</p> <p>Based on review of facility policy, facility scheduled mealtimes, meal delivery observations, resident council group interviews, resident and staff interviews it was determined that the facility failed to ensure that meals were served at regularly scheduled times for one of three meal observations (4/1/25-breakfast).</p> <p>Findings include:</p> <p>The facility Food and nutritional services policy last reviewed 9/18/24, indicated that meals will be provided within 45 minutes of scheduled meal time.</p> <p>During observation on 3/31/25, meal time posting stated the following meal time (breakfast arrives at 7:30 a. m.; lunch arrives at 11:30 a.m.; and dinner arrives at 5:30 p.m.).</p> <p>During an interview on 3/31/25, at 2:40 p.m. Resident R44 stated: the food is cold because it sits upstairs and then one hour later the trays are passed.</p> <p>During meal observations on 4/1/25, at 8:54 a.m. breakfast tray carts were observed on the Second floor.</p> <p>During an interview on 4/1/25, at 8:56 a.m. the Director of Nursing (DON) stated about tray time arrivals: the tray carts arrived 15 minutes ago.</p> <p>During an interview on 4/1/25, at 3:15 p.m. information was disseminated to Director of Nursing (DON) and Nursing Home Administrator (NHA) that the facility failed to ensure that meals were served at regularly scheduled times for breakfast on 4/1/25 as required.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p> <p>28 Pa Code 211.6(a) - Dietary Services</p>		

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</p> <p>Based on review of clinical records, facility documents, and staff interviews, it was determined that the facility failed to schedule an appointment for outside services in a timely manner for two of two residents reviewed (Resident R34 and R77).</p> <p>Findings include:</p> <p>Review of Resident R34's clinical record revealed that Resident R34 was admitted to the facility on [DATE], with diagnoses of tracheostomy (tube inserted through the neck to assist breathing) status, repeated falls, and gastro-esophageal reflux disease without esophagus (also known as GERD, occurs when stomach acid frequently flows back into the esophagus, leading to irritation and discomfort.)</p> <p>Review of Resident 34's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/28/25, indicated diagnoses were current.</p> <p>Review of Resident R34's physician order dated 3/11/25, indicated the resident was scheduled a tracheostomy evaluation on 3/19/25, at 10:00 a.m.</p> <p>Review of Resident R34's clinical record on 3/31/25, at 11:32 a.m. failed to reveal the resident went to the scheduled appointment as ordered.</p> <p>During a phone interview on 3/31/25, at 11:47 a.m. with Resident R34's otolaryngology provider's office, it was confirmed Resident R34 was evaluated on 3/19/25, and had a follow up appointment scheduled for 4/16/25.</p> <p>Review of Resident R34's clinical record on 3/31/25, at 11:57 a.m. failed to include evidence the facility was aware of the follow up appointment scheduled 4/16/25.</p> <p>During an interview on 3/31/25, at 1:59 p.m. the Director of Nursing and Nursing Home Administrator confirmed the facility failed to schedule an appointment for outside services in a timely manner for one of three residents reviewed (Resident R34).</p> <p>Review of the clinical record indicated Resident R77 was admitted to the facility on [DATE], with diagnoses of respiratory failure, immunodeficiency, and kidney transplant rejection.</p> <p>Review of Resident R77's Hospital Discharge Summary dated 3/3/25, indicated to follow up with the resident's transplant surgery office within three weeks. Call to schedule follow up appointment.</p> <p>Review of Resident R77's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/7/25, indicated diagnoses were current.</p> <p>Review of Resident R77's clinical record on 4/1/25, at 11:44 a.m. failed to include a physician order or evidence Resident R77 followed up with the transplant surgery office as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/1/25, at 11:50 a.m. Registered Nurse Supervisor, Employee E2 confirmed Resident R77's appointment was not scheduled.</p> <p>During an interview on 4/5/25, at 4:45 p.m. the Director of Nursing and Nursing Home Administrator confirmed the facility failed to schedule an appointment for outside services in a timely manner for two of two residents reviewed (Resident R34 and R77).</p> <p>28 Pa. Code 211.12(d)(3) Nursing services.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>27424</p> <p>Based on review of facility documentation and previous surveys and results of the current survey, it was determined that the facility Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed deficiencies.</p> <p>Findings include:</p> <p>The facility deficiencies and plans of corrections for a State Survey and Certification (Department of Health) survey ending March 13, 2025, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations.</p> <p>Findings of the current survey ending April 5, 2025, included deficiencies that were repeated from previous surveys and were new that reached of harm and potential harm (F600 as repeated and F695 as current).</p> <p>An interview on April 5, 2025, with Nursing Home Administrator confirmed that the facility had a previous deficiency on March 13,2025 and current deficiencies for F600 and F695, failed to correct quality deficiencies and ensure that plans to improve the delivery of care services effectively addressed deficiencies.</p> <p>Refer F600 and F695</p> <p>28 Pa. Code 201.18(e) (1)Management</p> <p>28 Pa. Code211.12(c)(d)(3) Nursing services</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49469</p> <p>Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to</p> <p>prevent cross contamination during a dressing change for one of three residents (Resident R22) failed to prevent cross contamination during a medication pass for two of three residents (Resident R9 and R12) and failed to ensure an infection control surveillance plan was implemented and staff and residents were tested in accordance with national standards.</p> <p>Findings include:</p> <p>Review of the facility policy Administering Medication last reviewed 9/18/24, indicate staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precaution, etc.) for the application of medications.</p> <p>Review of the facility policy Handwashing/Hand Hygiene last reviewed 9/18/24, indicate the facility considers hand hygiene the primary means to prevent the spread of infection. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personal, residents, and visitors.</p> <p>Review of the CDC (Center for disease control) Fact Sheet Enhanced Barrier Precaution indicates everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following high contact activities including but not inclusive to providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy and wound care: any skin opening requiring a dressing.</p> <p>Review of the Respiratory Virus Outbreak Toolkit dated 11/14/25, indicated sick health care personnel should stay home until they are fever free for 24 hours without fever-reducing medication. Test anyone showing signs or symptoms of a respiratory illness. Droplet precautions should be implemented for a resident diagnosed with influenza. An outbreak is considered over' when 14 days have passed since the last resident tested positive or became symptomatic (if no positive test). Any new infections in a resident would restart the 14-day countdown. Upon identification of an outbreak, a line list is completed to collect information about all ill cases (residents and staff). Each ill resident or staff member's information should be entered and information should be updated daily during the outbreak for all cases.</p> <p>Review of the facility policy Coronavirus Disease (COVID-19) - Identification and Management of Ill Residents dated 9/18/24, revealed the infection preventionist is responsible for establishing and overseeing screening and monitoring efforts. All surveillance findings are collected and reviewed daily by the infection preventionist.</p> <p>Review of the facility policy Coronavirus Disease (COVID-19) - Testing Staff dated 9/18/24, staff are instructed to report symptoms of COVID-19 for further management and test as soon as possible. During an outbreak testing approaches may consist of contact tracing or facility-wide testing.</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 - Many</p>	<p>During an observation completed on 4/2/25, at 12:38 p.m. during a dressing change for Resident R22 the following cross contamination opportunities were observed. Upon entering Resident R22's room Licensed Practical Nurse (LPN) Employee E11 placed a garbage bag on the over bed tray table, she exited the room and returned with a yellow disposable gown retrieved from the over the door bin and placed it on the dresser in front of Resident R22's TV. LPN Employee E11 placed the dressing supplies on top of it. LPN Employee E11 then donned her personal protective equipment (PPE). LPN Employee E11 removed the soiled dressing and placed into the garbage bag on the over bed table, she then removed her gown and gloves placed into garbage bag, washed her hands applied new gloves and continued to cleanse the wound without utilizing any other PPE. LPN Employee E11 placed the soiled supplies into the garbage bag removed her gloves washed her hands and again donned her PPE to complete the dressing change. Upon completion of dressing change LPN Employee E11 removed her PPE placed into the garbage bag, rolled up the gown from the TV stand and also placed into the garbage bag. LPN Employee E11 exited the room and failed to clean the bedside table or the TV stand.</p> <p>During an interview completed on 4/2/25, at 1:00 p.m. LPN Employee E11 confirmed not cleaning the overbed table or dresser surfaces utilized in the dressing change prior to or after. Using a yellow gown as a clean field and failing to utilize PPE during the complete dressing change.</p> <p>During a medication pass completed on 4/1/25, at 8:57 a.m. LPN Employee E9 was preparing medications for Resident R7, LPN Employee E9 was utilizing a washcloth that appeared to be wet for hand hygiene. The washcloth was in a side compartment of the medication cart. LPN Employee E9 indicated the washcloth had hand sanitizer on it. Resident R7 requested to hold her senna for this day. LPN Employee E9 removed the senna from the medication cup using her bare hands and handed the cup to the resident. After administering Resident R7's eye drops LPN Employee E9 utilized the washcloth to perform hand hygiene and returned it to the side compartment of the medication cart.</p> <p>During an interview completed on 4/1/25, at 9:13 a.m. LPN Employee E9 confirmed she removed Resident R7's senna with her bare hands and completed hand hygiene by wiping her hands with washcloth drenched in hand sanitizer and returning the washcloth to the side of the medication cart.</p> <p>During a medication pass completed on 4/1/25 at 9:24 a.m. LPN Employee E1 was preparing medications for Resident R9, LPN Employee 1 was utilizing the residents medication punch cards, LPN Employee E1 punched the medication into his bare hands prior to placing it into the medication cup. While preparing medications for Resident R12, LPN Employee E1 removed a bottle of Iron supplement from the stock medications. While removing the lid, it was dropped to the floor he picked the lid of the floor and placed it back onto the bottle and stored in the medication cart, no hand hygiene was observed and LPN Employee E1 continue to prepare the remaining medications for Resident R12.</p> <p>During an interview completed on 4/1/25, at 10:07 a.m. LPN Employee E1 confirmed placing medications into his bare hands, placing the lid back on the bottle after it had fallen to the floor and not completing hand hygiene.</p> <p>Review of information submitted to the Department of Health on 1/3/25, revealed Resident R281 tested positive for COVID-19. It was indicated the resident returned on 1/4/25, with isolation protocol in place.</p> <p>Review of Resident R281's clinical record failed to include an order for isolation for COVID-19.</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 - Many</p>	<p>During an interview on 4/4/25, at 8:54 a.m., the IP, Employee E8 stated, I am still just learning what to do. IP Employee E8 started this role in January 2025. IP, Employee E8 became certified as of 3/27/25. IP, Employee E8 stated the facility has not had an outbreak of COVID since 1/1/25, until now. When asked during an outbreak, how often are tests completed, IP, Employee E8 stated I got the dates written down, I don't want to guess. When asked how do you determine when the facility is no longer in an outbreak for COVID, IP, Employee E8 stated I think 21 days is the timeframe.</p> <p>A review of facility documentation on 4/4/25, at 9:04 a.m. failed to include a line listing for COVID-19 and Influenza.</p> <p>During an interview on 4/5/25, at 9:25 a.m. Director of Clinical Operations, Employee E24, confirmed the facility failed to implement COVID and Influenza monitoring, tracking, and testing in accordance with state and federal guidance.</p> <p>During an observation an interview on 4/4/25, at 9:56 a.m. LPN, Employee E28 was observed coughing and stated I was up all night coughing, all my joints are aching. LPN, Employee E28 stated I told HR Employee E27 and the DON and they did not tell me to test for COVID, I can do it now.</p> <p>During an interview on 4/5/25, at 11:22 a.m. the DON was asked which days the facility conducts testing during a COVID outbreak and stated there are no specific days, twice a week. When asked how does the facility determine when the facility is no longer in an outbreak for COVID, it was indicated the completion of negative testing, unless they extend past day 10. If positive after day 10, then testing is extended if showing signs and symptoms of infection.</p> <p>During an interview on 4/5/25, at 4:45 p.m. the Director of Nursing and Nursing Home Administrator confirmed that the facility failed to ensure an infection control surveillance plan was implemented and staff and residents were tested in accordance with national standards.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 211.12 (d)(1)(2)(3) Nursing Services.</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Implement a program that monitors antibiotic use.</p> <p>46337</p> <p>Based on review of the facility's infection control policies and procedures and staff interview, it was determined that the facility failed to implement an antibiotic stewardship program for ten of ten months (June 2024 through February 2025).</p> <p>Findings include:</p> <p>Review of facility policy Antibiotic Stewardship Program Policy dated 9/18/24, indicated the purpose of the facility's antimicrobial stewardship program is to monitor the use of antibiotics in the residents. If an antibiotic is ordered the indications for use will be included.</p> <p>Review of the facility's Infection Control surveillance for October 2024 through February 2025, failed to include documentation to indicate that antibiotic monitoring was completed.</p> <p>During an interview on 4/4/25, at 8:51 a.m., the IP (infection preventionist) Employee E8 was unable to provide antibiotic monitoring from June 2024 until September 2024. October 2024 through February 2024 failed to include documentation including diagnoses and responses to indicate that antibiotic monitoring was completed. IP, Employee E8 stated, I am still just learning what to do. IP Employee E8 started this role in January 2025.</p> <p>During an interview on 4/4/25, at 11:22 a.m. the Nursing Home Administrator and Director of Nursing (DON) confirmed that the facility failed to implement an antibiotic stewardship program for ten of ten months (June 2024 through February 2025).</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 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>46337</p> <p>Based on a review of select facility policy and staff interview, it was determined the facility failed to designate a qualified individual(s) onsite, who is responsible for implementing programs and activities to prevent and control infections (January 2025 to March 2025).</p> <p>Findings included:</p> <p>The Centers for Medicare and Medicaid Services regulation S483.80(b)(3) states the facility must designate one or more individuals as the infection preventionist who are responsible for the facility's Infection Prevention and Control Program. The IP (infection preventionist) must work at least part-time at the facility, physically work onsite in the facility, have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field, cannot be an off-site consultant or perform the IP work at a separate location.</p> <p>During an interview on 4/4/25, at 8:51 a.m., the IP, Employee E8 stated, I am still just learning what to do. IP Employee E8 started this role in January 2025. IP, Employee E8 became certified as of 3/27/25.</p> <p>During an interview on 4/4/25, at 11:22 a.m. the Nursing Home Administrator and Director of Nursing (DON) confirmed the facility failed to designate a qualified individual(s) onsite, who is responsible for implementing programs and activities to prevent and control infections (January 2025 to March 2025).</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1) Management.</p>		

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<p>F 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>49469</p> <p>Based on review of facility policy, facility documents, and staff interview, it was determined that the facility failed to provide training on Quality Assurance and Performance Improvement (QAPI) for five of five staff members (Employee E21, E26, E27, E28, and E29).</p> <p>Findings include:</p> <p>Review of facility education documents for the year 2024, revealed the following concerns:</p> <p>Review of Nurse Aide (NA) Employee E21's facility provided information did not include training on QAPI.</p> <p>Review of NA Employee E26's facility provided information did not include training on QAPI.</p> <p>Review of NA Employee E27's facility provided information did not include training on QAPI.</p> <p>Review of NA Employee E28's facility provided information did not include training on QAPI.</p> <p>Review of NA Employee E29's facility provided information did not include training on QAPI.</p> <p>During an interview 4/4/25, at 2:30 p.m. Human Resource (HR) Employee E30 confirmed that the facility failed to provide training on Quality Assurance and Performance Improvement (QAPI) for five of five staff members. (Employee E21, E26, E27, E28, and E29).</p> <p>28 Pa Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa Code: 201.18 (b)(1) Management.</p> <p>28 Pa Code: 201.20 (a) Staff development.</p>		