STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396098	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UPMC Magee-Womens Hospital Tcu	300 Halket Street Pittsburgh, PA 15213

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman upon discharge for two out of three closed resident records (Residents CR25 and Resident CR26).Findings include: The facility Admission, transfer, discharge policy last reviewed on 9/25/25, indicated that the discharge of a resident from the facility is conducted in an organized manner, focusing on continuity of care. Review of Resident CR25's admission record indicated he was admitted on [DATE]. Review of Resident CR25's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 9/16/25, indicated that he had diagnoses which included diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), hypertension (a condition impacting blood circulation through the heart related to poor pressure), and coronary artery disease (narrowing/blockage of vessels that carry blood and oxygen to the heart). Review of Resident CR25's discharge plan documentation indicated he was discharged home with his wife and home health services. Review of Resident CR26's admission record indicated he was admitted on [DATE].Review of Resident CR26's MDS assessment dated [DATE], indicated he had diagnoses that included left clavicle fracture, hypertension and osteoporosis. Review of Resident CR26's discharge records indicated he was discharged to a nursing facility on 2/24/25.Review of facility notifications to the State Ombudsman office did not include notifications of Closed Resident Record CR25 and CR26 dischargesDuring an interview on 11/25/25, at 9:30 am. the Nursing Home Administrator (NHA) confirmed that the facility failed to notify the Office of the State Long-Term Care Ombudsman upon discharge for Closed Resident Records R25 and R26 as required. 28 Pa. Code: 201.29 (ac.3) (2) Resident rights.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 (a tube inserted in the stomach through the abdomen) received appropriate treatment and services to prevent potential complications for one of three residents (Resident R30).Findings include: Review of facility policy Tube Feeding via Enteral Feeding Pump last reviewed 9/25/25, indicated to deliver a liquid feeding formula directly to the stomach. Enteral feeding and tubing are changed every 24 hours or when a new bottle is hung. Label feeding bag/bottle with date and time hung. Review of the clinical record indicated Resident R30 was admitted to the facility on [DATE], with diagnosis of breast cancer, hypotension (low blood pressure) and abdominal discomfort. Review of a nutrition communication note dated 11/21/25, indicated Resident R30's recommended tube feeding formula is [NAME] Farm 1.5 calorie with goal rate of 50 milliliters (ml) per hour with water flush of 150 ml every four hours. Review of Resident R30's nursing notes dated 11/24/25, indicated tube feeding method continuous with rate of 50ml/hour tolerating without feeling of fullness. During an observation on 11/24/25, at 9:11 a.m. Resident R30's enteral feeding formula and water bag were noted in room infusing via pump. The formula and water bag failed to be labeled with a date or time hung. During an interview on 11/24/25, at 9:15 a.m. Registered Nurse Employee E2 stated I know she just hung it last night. During an interview on 11/24/25, at 9:15 a.m. RN Employee E2 confirmed that the facility failed to ensure that residents with an enteral feeding tube received appropriate treatment and services to prevent potential complications for one of three residents (Resident R30). 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.10(c) Resident care policies.28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to provide adequate treatment and care for a peripherally inserted catheter (a thin plastic tube inserted into a vein using a needle) in accordance with professional standards of practice for one of two residents (Resident R33). Findings include: Review of the facility policy Intravenous (IV) Therapy: Peripheral, Including Midlines last reviewed 9/25/25, indicates to maintain venous access, administer continuous/intermittent intravenous fluids, nutrition, medications, and blood products over a specific time frame. All registered Nurses and Licensed Practical Nurses that complete the IV therapy program are responsible for including but not inclusive to:. IV site inspection a minimum of every shift Maintain a clean, dry and intact dressing over insertion site Document date and time. Review of Resident R33's clinical record indicates an admission date of 11/12/25, with the diagnosis of hernia (when an organ or fatty tissue squeezes through a weak spot in muscle or connective tissue) repair, muscular deconditioning (wasting or thinning of muscle mass) and obesity. Review of Resident R33's clinical documentation indicated a size 22-gauge peripheral catheter was inserted to the left wrist on 11/23/25. During an observation on 11/24/25, at 9:32 a.m. Resident R33 was sitting in her wheelchair, a peripheral IV access site was noted to her left wrist. The IV site was noted not to have been labeled with a date or time of insertion. During an interview on 11/24/25, at 9:34 a.m. Licensed Practical Nurse Employee E3 confirmed the IV access site dressing did not contain a date or time of insertion and that the facility failed to provide adequate treatment and care for a peripherally inserted catheter in accordance with professional standards of practice for one of two residents (Resident R33). 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing Services.28 Pa. Code: 201.14(a) Responsibility of licensee

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F 0812 Level of Harm - Potential for minimal harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on a review of policy, observation and staff interview, it was determined that the facility failed to maintain the cleanliness and sanitation of equipment to prevent the potential for cross-contamination or foodborne illness in the Transition Care Unit (TCU) Dining Room (3rd floor, 3100 unit).Findings include: Review of facility policy SRC-Food and Nutrition - Sanitation-AB dated 9/30/25, indicated all employees are responsible for keeping equipment and the department clean. All kitchen equipment will be cleaned and sanitized following each use. During an observation on 11/24/25, at 10:45 a.m., of the dining room on the TCU, which included the Resident Pantry area, revealed the microwave oven's (kitchen appliance used to reheat foods) interior cooking surfaces were covered with dried food particles and splatters of dried food debris. During an interview on 11/24/25, at 11:02 a.m., the Nursing Home Administrator (NHA) confirmed the unit's microwave oven needed cleaned and sanitized and that the facility failed to maintain the cleanliness and sanitation of equipment to prevent the potential for cross-contamination or foodborne illness in the Transition Care Unit (TCU) Dining Room (3rd floor, 3100 unit). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1) Management.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review and staff interview, it was determined that the facility failed to provide accurate and timely documentation related to the COVID-19 (a respiratory disease) vaccine for five out of five residents (Resident R6, R9, R27, R28, and R36). Findings include: Review of facility policy Infection Control - Immunizations dated 9/25/25, indicated Pneumococcal, Covid, and Influenza immunizations will be offered to residents. Other immunizations will be offered as indicated. The purpose is to prevent transmission of agents. Upon admission, establish immunization status with resident or resident representative. Review of Resident R6's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/22/25, indicated diagnoses of hypertension, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and anemia (too little iron in the body causing fatigue). MDS Section O- Special treatment, Procedures, and Programs O0350 indicated COVID-19 vaccine was coded a 0- resident not up to date. Review of clinical records indicated that Resident R6's last received a COVID-19 vaccination on 2/9/2022.During a review of Resident R6's clinical record on 11/24/25, at 12:35 p.m. failed to include documentation that a Covid-19 booster vaccine was offered. Review of Resident R9's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R9's MDS dated [DATE], indicated diagnoses of hypertension, diabetes, and deep vein thrombosis (blood clot forms in a deep vein). Review of clinical records indicated that Resident R9's last received a COVID-19 vaccination on 12/2/21. During a review of Resident R9's clinical record on 11/24/25, at 12:37 p.m. failed to include documentation that a Covid-19 booster vaccine was offered. Review of Resident R27's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R27's MDS's dated 11/14/25, indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), edema, and osteoporosis (condition when the bones become brittle and fragile). MDS Section O- Special treatment, Procedures, and Programs O0350 indicated COVID-19 vaccine was coded a 0- resident not up to date. Review of clinical records indicated that Resident R27's last received a COVID-19 vaccination on 4/14/21. During a review of Resident R27's clinical record on 11/24/25, at 12:39 p.m. failed to include documentation that a Covid-19 booster vaccine was offered. Review of Resident R28's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R28's MDS's dated 11/19/25, indicated diagnoses of osteoporosis, chronic pain, and epilepsy (disorder of the brain characterized by repeated seizures). Review of clinical records indicated that Resident R28's last received a COVID-19 vaccination on 11/11/21. During a review of Resident R28's clinical record on 11/24/25, at 12:43 p.m. failed to include documentation that a Covid-19 booster vaccine was offered. Review of Resident R36's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R36's MDS's dated 11/24/25, indicated diagnoses of high blood pressure, cellulitis (bacterial skin infection), and gastroesophageal reflux disease (GERD-chronic digestive disorder where stomach acid flows back into throat). MDS Section O- Special treatment, Procedures, and Programs O0350 indicated COVID-19 vaccine was coded a 0- resident not up to date. Review of clinical records indicated that Resident R36's last received a COVID-19 vaccination on 7/7/22. During a review of Resident R36's clinical record on 11/24/25, at 12:47 p.m. failed to include documentation that a Covid-19 booster vaccine was offered. During an interview on 11/24/25, at 1:17 p.m. Registered Nurse Assessment Coordinator Employee E1 stated the facility does not offer Covid vaccines to residents and confirmed that the facility failed to provide accurate and timely documentation related to the COVID-19 (a respiratory disease) vaccine for five out of five residents (Resident R6, R9, R27, R28, and R36). 28 Pa. Code 211.5(f)(i)-(xi) Clinical records