

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/10/2024
NAME OF PROVIDER OR SUPPLIER Providence Point Healthcare Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Adams Ave Pittsburgh, PA 15243	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311</p> <p>Based on a review of clinical records, facility documents, and resident and staff interviews, it was determined that the facility failed to provide appropriate assistance to prevent falls, resulting in actual harm of a leg fracture for one of three residents reviewed (Resident R1).</p> <p>Findings include:</p> <p>Review of the facility policy Activities of Daily Living (ADL) dated May 2023, indicated the ability of each resident to meet the demands of daily living is assessed on admission and regularly thereafter.</p> <p>Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE].</p> <p>Review of the Minimum Data Set (MDS - periodic assessment of resident's care needs) dated 2/15/24, revealed diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles) and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Section G: Functional Abilities and Goals indicated Resident R1 required Substantial/maximal assistance meaning that the helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort for 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).</p> <p>Further review of the MDS dated [DATE], revealed that during the lookback assessment period (2/13/24 - 2/15/24) Resident R1 was documented by staff to have been Dependent on staff to roll left and right, meaning that the help does all of the effort. Resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity.</p> <p>Review of Resident R1's plan of care, as of 5/4/24, for fall risk and ADL (Activities of daily living) care both indicated for facility staff to follow physical and occupational therapy recommendations.</p> <p>Review of the clinical record revealed Resident R1 received physical therapy services from 5/30/23, through 6/20/23. Resident R1 was documented as requiring Substantial/maximal assistance to roll left and right. No further physical therapy documentation was available after this date.</p> <p>(continued on next page)</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of point of care documentation from 4/4/24, through 5/4/24, revealed Resident R1's assistance level provided while rolling back and forth was documented 90 times, revealing the following:</p> <p>Total Dependence: 59 of 90 times (approximately 66%).</p> <p>Extensive Assistance: 25 of 90 times (approximately 28%).</p> <p>Limited Assistance: 6 of 90 times (approximately 6%).</p> <p>Review of a progress note dated 5/5/24, at 10:10 p.m. revealed, Called to Nursing Unit by nursing. Resident sitting on the floor next to her bed. 2 CNAs (nurse aides) had just transferred her to bed using the Hoyer lift. The CNA was changing her because she was incontinent of urine; she was turned onto her left side and slid off the bed and landed on her buttocks with her knees bent; resident stating My left knee is broken resident wiggles toes and can move feet. Unable to lift legs which is the resident's baseline. resident stating 10/10 pain to left knee; no swelling or bruising; no open areas; resident unable to move; [Provider] notified; Order received to transfer resident to the Emergency department for evaluation.</p> <p>Review of facility provided information/documentation dated 5/6/24, indicated On 5/5/24 at approx. 10:10 pm while CNA (nurse aide) was providing incontinence care, in bed, while resident was rolled to her left side, her legs slid off of the mattress. CNA was unable to lift resident's legs back into bed due to lymphedema (the build-up of fluid in soft body tissues) and obesity and assisted resident to the floor. Resident landed on her knee and buttocks and complained of left leg pain. Resident was immediately assessed by nurse. Family and MD notified.</p> <p>Review of a statement written by Nurse Aide (NA) Employee E1 dated 5/6/24, revealed I [NA Employee E1] 3-11 shift witness. My resident [Resident R1] slid off the bed while doing the resident care. Today. 03-5th-2024 (5/6/24) Sunday at 10:00 p.m. Me [NA Employee E1] and my co-worker [NA Employee E2] transferred [Resident R1] to her bed using Hoyer lift after that, my coworker [NA Employee E2] had to go attend her residents on C-Hall. I helped [Resident R1] to roll to her left side holding the bed rails, which she usually does. I changed her. I was about to be done she wet the bed again and I had to change the entire bed. I tugged the bed set underneath her. She started screaming, I am going to fall so I tried to pull her back but she was too big for me to pull her. I ran in front of her, her left side and there wasn't so much I could do so I helped her land on a floor her leg she was on her knee and she straightened it out but she was complaining about her left leg pain. I notified the charge nurse.</p> <p>Review of hospital documentation dated 5/6/24, at 2:12 a.m. indicated an x-ray of the left knee was completed, which revealed a fracture of the distal femoral diaphysis (fracture of the lower portion of the upper leg bone).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a follow-up, clarification interview completed on 5/10/24, at 12:27 p.m. NA Employee E1 confirmed that she was the only staff member providing care to Resident R1 when she slid from the bed. NA Employee E1 stated that she was on the side of the bed closest to the room window. She confirmed that Resident R1 was rolled away from her, and due to Resident R1's size, she was unable to reach over her to provide incontinence care, and had to be positioned behind her to reach to clean her. NA Employee E1 stated that when Resident R1 began to slide from the bed, she ran to the other side of the bed to try to catch her, and began yelling out for other staff to assist her. NA Employee E1 stated that no other staff heard her yell, and she was unable to keep Resident R1 from fully sliding to the floor. NA Employee E1 also stated it is not usual for a resident to be rolled away from the person providing care; normally she doesn't ever do that when providing care.</p> <p>During an interview with NA Employee E2 on 5/10/24 at 1:00 p.m., confirmed that residents should be rolled towards the person providing care.</p> <p>During an interview on 5/10/24, at approximately 1:30 p.m. the Nursing Home Administrator in training confirmed that the facility failed to provide appropriate assistance to prevent falls, resulting in actual harm of a leg fracture for Resident R1.</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 201.20(a)(b) Staff development</p> <p>28 Pa. Code 201.29(a)(c)(d) Resident rights</p>		