STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396124	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Point Healthcare Residence	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31343 Based on review of facility policies, resident clinical records, documentation provided by the facility and staff interview, it was determined that the facility failed to ensure that a resident was free from neglect, which resulted in a skin tear requiring a treatment for one of four residents (Resident R7). Findings include: Review of the United States Code of Federal Regulations (CFR), 42 CFR S483.12. Freedom from Abuse, Neglect, and Exploitation defined neglect 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. Review of facility policy Preventing Resident Abuse last reviewed on 5/24, indicated that residents will not be subject to physical, mental, etc. abuse. Annual training of all employees will be conducted to ensure the knowledge of the abuse policy. Policies and procedures have been developed to document the facilities philosophy regarding the elderly. The policies are reviewed and revised as needed to comply with current regulations and standards of care. Close scrutiny of incident reports for targeted residents or trending is completed. The alleged abuser will be informed of the allegation and removed from the area. They will be asked to prepare a statement and may be placed on leave, pending the outcome of the investigation. Review of the facility policy Incident/ Event Report, last reviewed on 5/24, indicated that the facility will track the treatment and evaluation of incidents such as skin tears, lacerations, bruises and falls to formulate preventive practices. Review of the clinical record indicated that Resident R7 was admitted to the facility on [DATE], with diagnoses which included dementia with other behavioral disturbances, atrial fibrillation(irregular heart beat), a pacemaker, difficulty walking, prescience of an artificial heart valve prescience of artificial knees and left hip and malnutrition. Review of the Minimum Data Set (MDS - periodic assessment of a resident's abilities and care needs) dated 6/4/24, indicated the diagnoses remained current. Review of physician orders indicated Resident R7 requires assistance of two for care provided while she is in bed. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note dated 4/18/24, indicated that Nurse Aide (NA) Employee E 1 told Licensed Practical Nurse (LPN) Employee E2 that around 5:30 a.m., doing rounds she was turning resident and realized once she turned resident's back towards her, resident arms had been folded and probably pressure caused some shearing resulting in the skin opening. This nurse observed skin opening to left forearm of 5 x 1.5 cm. Review of an incident report dated 4/18/24, indicated information as above. Review of a written statement by NA Employee E1 dated 4/18/24, indicated at 5:30 a.m., doing rounds, I was turning Resident R7 and realized once I turned her back towards me, her arms had been folded and I think the pressure caused some shearing resulting in the tear. I notified the nurse immediately. Review of a written statement by Registered Nurse Employee E3 dated 4/18/24, indicated, At 5:30 a.m., during am care, Resident R7 sustained a 5 cm x 1.5 c,m, skin tear. The physician was called and a treatment was obtained. A Summary also on the statement form indicated Resident R7 has dementia with poor safety awareness, and a treatment had been ordered. During an interview on 7/31/24, at 8:39 a. m., the Director of Nursing (DON) stated that she had looked into the incident and did not identify it as neglect, but after re- review, she could see how it could be. The DON confirmed that the facility failed to ensure that Resident R7 was free from neglect, which resulted in a skin tear requiring treatment and failed to protect Resident R7 from potential of further neglect/ abuse during the investigation. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 201.29(a)(c)(d)(j) Resident rights. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3) Nursing services.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31343 Based on review of facility policy, facility documents, clinical records, and staff interviews, it was determined that the facility failed to identify and investigate incidents of possible neglect and abuse for two of seven residents (Residents R7 and R28). Findings include: Review of the facility policy Preventing Resident Abuse, last reviewed May 2024, with a previous review date of May 2023, indicated that every complaint or allegation of resident abuse or neglect will be immediately reported to the Director of Nursing(DON) by the charge nurse and the DON will notify the Administrator The person receiving the report will make investigation a priority in order to protect the resident and gather data in a timely manner. Incidents and accidents are investigated at the time of the discovery. Review of the clinical record indicated that Resident R7 was admitted to the facility on [DATE], with diagnoses which included dementia with other behavioral disturbances, atrial fibrillation (irregular heart beat), a pacemaker, difficulty walking, prescience of an artificial heart valve prescience of artificial knees and left hip and malnutrition. A review of the Minimum Data Set (MDS - periodic assessment of a resident's abilities and care needs) dated 6/4/24, indicated the diagnoses remained current. Review of current physician orders indicated Resident R7 requires assistance of two for care provided while she is in bed. Review of a progress note dated 4/18/24, indicated that Nurse Aide (NA) Employee E 1 told Licensed Practical Nurse (LPN) Employee E2 that around 5:30 a.m., doing rounds she was turning resident and realized once she turned resident's back towards her, resident arms had been folded and probably pressure caused some shearing resulting in the skin opening. This nurse observed skin opening to left forearm of 5 x 1.5 cm. During an interview on 7/31/24, at 8:39 a. m., the Director of Nursing (DON) stated that she had looked into the incident and did not identify it as neglect. The DON confirmed that the facility failed to ensure that Resident R7 was free from neglect, which resulted in a skin tear requiring treatment. Review of the clinical record indicated that Resident R28 was admitted to the facility on [DATE], with diagnoses which included Alzheimer's disease, dementia with behavioral disturbances, Parkinsonism (tremors, rigidity and unstable posture), anxiety disorder and low back pain. A review of the MDS dated [DATE], indicated the diagnoses remained current. Review of a physician order dated 4/4/24, indicated Resident R28 was to be transferred with assistance of two for safety. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Grievance Form dated 6/9/24, indicated Resident R28's family submitted a concern with staff transferring him from his wheelchair into bed by lifting him without a second staff person as ordered. During an interview on 7/29/24, at 1:56 p.m., the Nursing Home Administrator and DON confirmed that the facility failed to identify and investigate the potential of neglect for Resident R28. 28. Pa Code 201.14(a) Responsibility of licensee. 28. Pa Code 201.18(b)(1)(e)(1) Management. 28. Pa. Code 211.12(d)(1)(5) Nursing services.