| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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| | 395743 | A. BLDG: 00<br>B. WING: | 12/19/2024 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
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| **CARNEGIE PARK POST ACUTE**<br>STATE LICENSE NUMBER: **381502** | **1848 GREENTREE ROAD**<br>**PITTSBURGH, PA 15220** |

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| F 0000 | INITIAL COMMENT<br><br>Based on an Abbreviated Survey in response to three complaints, completed on December 19, 2024, it was determined that Carnegie Park Post Acute was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations. | F 0000 | | |
| F 0684<br><br>SS=E | | F 0684 | | |

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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| F 0684<br><br>SS=E | Continued from page 1<br><br>483.25 Quality of Care<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br><br>This REQUIREMENT is not met as evidenced by: | F 0684 | Residents R1, R2, R3, R4 and R5 had no ill effects from F0684.<br><br>Any residents with compression stockings, ted hose and ace wraps will be audited for correct application. Identified deficient practice will be corrected upon notation with 1:1 education and return demonstration competency as indicated.<br><br>To prevent future occurrences, nurses will receive education on maintenance and use of compression stockings, ted hose and ace wraps.<br><br>Director of Nursing and/or designee will complete audits of maintenance and use of compression stockings, ted hose and ace wraps at random with 4 A/O residents 2x a week x 1 month; then monthly thereafter with reporting through Quality Assurance and Process Improvement Committee for review and/or recommendation ongoing | Completion Date: **02/10/2025**<br>Status: **APPROVED**<br>Date: **01/22/2025** |

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| F 0684<br><br>SS=E | Continued from page 2<br><br>Based on observations and resident and staff interviews, it was it was determined that the facility failed to make certain that residents were provided appropriate treatment and care for five of ten residents (Resident R1, R2, R3, R4, and R5).<br><br>Findings include:<br><br>Review of Resident R1's admission record indicated he was admitted to the facility on 7/28/21.<br><br>Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 11/5/24, included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), high blood pressure, and edema (swelling caused by too much fluid trapped in the body's tissues).<br><br>Review of an active physician order dated 9/6/24, indicated Resident R1 should have ACE wraps (stretchable elastic bandages) removed from both | F 0684 | | |

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| F 0684<br><br>SS=E | Continued from page 3<br><br>legs at the hour of sleep. No active order was noted to place ACE wraps on.<br><br>During an observation on 12/11/24, at approximately 11:35 a.m. Resident R1 had the ACE wraps on both legs applied in the direction from the toes to the knees, and then reversing from the knees to the toes.<br><br>Review of Resident R2's admission record indicated she was admitted to the facility on 1/25/22.<br><br>Review of the MDS dated 9/3/24, included diagnoses of heart failure. high blood pressure, and arthritis (inflammation of one or more joints, causing pain and stiffness).<br><br>Review of an active physician order dated 7/20/24, indicated Resident R2 should have ACE wraps applied to both legs from toes to knees, on in the morning prior to getting out of bed, and remove nightly. | F 0684 | | |

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| F 0684<br><br>SS=E | Continued from page 4<br><br>During an observation on 12/11/24, at approximately 2:07 p.m. Resident R2 had the ACE wrap on her left leg applied in the direction from the toes to the knees, and then reversing from the knees to the toes.<br><br>Review of Resident R3's admission record indicated she was admitted to the facility on 8/9/24.<br><br>Review of the MDS dated 11/13/24, included high blood pressure, chronic kidney disease (gradual loss of kidney function), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life).<br><br>Review of a physician order dated 12/2/24, indicated Resident R3 should have ACE wraps applied to her left lower extremity every morning and off at the hour of sleep.<br><br>During an observation on 12/11/24, at approximately 2:28 p.m. Resident R3 did not have ACE wraps on. | F 0684 | | |

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| F 0684<br><br>SS=E | Continued from page 5<br><br>During an interview and observation on 3/21/24, at approximately 11:25 a.m. Resident R83 stated that she had removed the ACE wrap on her left leg due to it being painful from being too tight. Observation of the right leg revealed that the ACE wrap was applied tightly, particularly over the ankle, with significant swelling both above and below the ankle.<br><br>Review of Resident R4's admission record indicated she was admitted to the facility on 12/20/21.<br><br>Review of the MDS dated 9/9/24, included diagnoses of heart failure, coronary artery disease (damage or disease in the heart's major blood vessels), and history of a stroke.<br><br>Review of a physician order dated 6/5/24, indicated Resident R4 should have ACE wraps applied to both lower extremities in morning and off in the evening, on Mondays, Wednesdays, and Fridays.<br><br>During an observation on Wednesday, 12/11/24, at | F 0684 | | |

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| F 0684<br><br>SS=E | Continued from page 6<br><br>approximately 2:30 p.m. Resident R4 was noted not to have ACE wraps on.<br><br>Review of Resident R5's admission record indicated he was admitted to the facility on 10/22/16.<br><br>Review of the MDS dated 11/12/24, included diagnoses of coronary artery disease, high blood pressure, and lymphedema (the build-up of fluid in soft body tissues).<br><br>Review of a physician order dated 12/6/24, indicated Resident R5 should have ACE wraps applied to both legs from toes to below knees, on in the morning, and off in the evening.<br><br>During an observation on 12/11/24, at approximately 2:45 p.m. Resident R5 was noted not to have ACE wraps on.<br><br>During an interview on 12/11/24, at approximately 2:48 p.m. Licensed Practical Nurse Employee E1 confirmed Resident R5 had swollen lower legs, and | F 0684 | | |

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| F 0684<br><br>SS=E | Continued from page 7<br><br>did not have ACE wraps on.<br><br>During an interview on 12/11/24, at approximately 3:10 p.m. the Director of Nursing confirmed the facility failed to make certain that residents were provided appropriate treatment and care for five of ten residents.<br><br>28 Pa. Code 201.14(a) Responsibility of licensee.<br><br>28 Pa. Code 201.29(a)(c)(d)(j) Resident rights.<br><br>28 Pa. Code 211.10(c)(d) Resident care policies.<br><br>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services. | F 0684 | | |
| F 0725<br><br>SS=E | | F 0725 | | |

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| F 0725<br><br>SS=E | Continued from page 8<br><br>483.35(a)(1)(2) Sufficient Nursing Staff<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br><br>This REQUIREMENT is not met as evidenced by: | F 0725 | Social services reviewed grievance log and found no unaddressed care concerns. Social services interviewed twenty alert and oriented residents, who at the time did not express any delay of care or overall care issues. Social services additionally walked the entire building performing visual audits to include any residents who are not alert and oriented to ensure timely care was provided. At this time there are no active grievances related to delay in care due to staffing.<br><br>Any residents who have a shower report that is identified as refusing and or N/A identified, the assigned staff will have 1:1 education from the nurse educator/ designee.<br><br>To prevent future occurrences, nurses and aides will receive education by the Nurse Educator/designee on the importance of timely call bell response as well as the importance of showers/ hygiene. The aides and | Completion Date: **02/10/2025**<br>Status: **APPROVED**<br>Date: **01/23/2025** |

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| F 0725<br><br>SS=E | Continued from page 9 | F 0725 | nurses will also be educated by the Nurse Educator/designee on completion of ADLs emptying urinals, making bed, etc.<br><br>Director of Nursing and/or designee will complete audits of call bells, shower/ bathing record at random with 4 residents on each unit 2x a week x 1 month; then monthly thereafter with reporting through Quality Assurance and Process Improvement Committee for review and/or recommendation ongoing. | |

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| F 0725<br><br>SS=E | Continued from page 10<br><br>Based on review of facility policy and resident interviews and observations, it was determined that the facility failed to ensure sufficient staffing to meet resident need for ten of thirteen residents (Resident R2, R6, R7, R8, R9, and R10, and four confidential residents: RB, RC, RD, and RE).<br><br>Findings include:<br><br>Review of the facility policy, "Answering the Call Light" dated 7/13/23, indicated the facility will provide timely responses to the resident's requests and needs.<br><br>During a group interview of five residents who requested confidentiality on 12/11/24, when asked if they felt the facility had sufficient staff, two of the five (Confidential Residents RB and RC) stated "No." When asked if call light response times were overlong, four of the five confirmed that they were. Confidential Resident RB stated, "We can't sit for hours with a wet diaper. We aren't animals." | F 0725 | | |

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| F 0725<br><br>SS=E | Continued from page 11<br><br>Confidential Resident RC stated, "I've waited six hours." Confidential Resident RC further stated that she has been told by staff that they don't have time to take her to the bathroom, and she needs to have her bowel movement in her brief. Confidential Resident RD stated, "I've waited two hours. I couldn't hold it, I had an accident." Confidential Resident RE stated, "Those lights be long."<br><br>During an observation on 12/11/24, at 11:20 a.m. Resident R6 was noted to be malodorous, with unclean smelling breath.<br><br>Review of Resident R6's shower/bathing record indicated that Resident R6 received showers on Mondays and Thursdays. Review of this record from 11/25/24, through 12/19/24, revealed the following:<br>-11/25/24: The bathing was documented as "Not Applicable."<br>-11/28/24: The bathing was documented as "Not Applicable."<br>-12/02/24: No documentation. | F 0725 | | |

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| F 0725<br><br>SS=E | Continued from page 12<br><br>-12/05/24: The bathing was documented as "Refused."<br>-12/09/24: The bathing was documented as "No."<br>-12/12/24: No documentation.<br>-12/16/24: The bathing was documented as "Not Applicable."<br>-12/16/24: The bathing was documented as "Yes."<br><br>During an interview and observation on 12/11/24, at 2:00 p.m. Resident R2 stated the facility, "It's neglect. They really need more help."<br><br>During an interview on 12/11/24, at 2:15 p.m. Resident R7, when asked if he felt the facility had sufficient staff stated, "So-so." Resident R7 further stated that his roommate (Resident R8) has to wait a long time for call light responses.<br><br>During an interview and observation on 12/11/24, at 2:16 p.m. Resident R8 was noted to be seated on the edge of his bed, semi-reclined on his right side, with his legs hanging toward the floor. Resident R8 stated that he is unable to lift his legs, and was | F 0725 | | |

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| F 0725<br><br>SS=E | Continued from page 13<br><br>currently waiting to be assisted back to bed. When asked how long he had been waiting, Resident R8 stated, "Forty minutes."<br><br>During an interview on 12/11/24, at 2:27 p.m. Resident R9, when asked if she felt the facility had sufficient staff stated, "They could use some more aides." When asked about call light response stated, "Fifteen to twenty minutes, when they have more than one aide." When asked if she received sufficient showers, Resident R9 stated, "I was supposed to get two this week, I only got one. I'm washing myself up."<br><br>During an observation on 12/11/24, at 2:45 p.m. Resident R10, was observed to be seated in his room. When the room was entered, the smell of urine was very strong. The overbed table had three full urinals on it. The sheets were observed to have a large yellow area, which was felt to be dry. The blanket was wet with urine. Resident R10 has noted to be in wet clothing, with what appared to be urine pooled on the floor underneath him. | F 0725 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | (X5) COMPLETE DATE |
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| F 0725<br><br>SS=E | Continued from page 14<br><br>During an interview on 12/11/24, at 2:50 p.m. Licensed Practical Nurse Employee E1 confirmed that Resident R10 was dressed in wet clothing, with what appeared to be urine on the floor under him, full urinals on the overbed table, and sheets and blanket soiled with what appeared to be urine.<br><br>During an interview on 12/19/24, at approximately 10:00 a.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to ensure sufficient staffing to meet resident need for ten of thirteen residents.<br><br>28 Pa. Code 201.14(a) Responsibility of licensee.<br><br>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services. | F 0725 | | |
| F 0865<br><br>SS=D | | F 0865 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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| | 395743 | A. BLDG: 00<br>B. WING: | 12/19/2024 |

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| F 0865<br><br>SS=D | Continued from page 15<br><br>483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) QAPI Prgm/Plan, Disclosure/Good Faith Attmpt<br><br>§483.75(a) Quality assurance and performance improvement (QAPI) program.<br>Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:<br><br>§483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;<br><br>§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;<br><br>§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and | F 0865 | After notation, the facility conducted a QAPI meeting to review the facility policy regarding the Quality Assurance and Performance Improvement program.<br><br>All residents with compression stockings, ted hose and ace wraps will be identified monthly during QAPI to ensure proper monitoring. Director of Nursing/designee will observe nurses apply/remove compression stocking and report findings to administrator.<br><br>Director of Nursing/Designee will monitor residents ordered compression stockings, ted hose, and ace wraps for proper application and removal daily. Director of Nursing/designee will report findings to administrator monthly at QAPI meeting.<br><br>To prevent future occurrences from happening the Administrator will educate the Director of Nursing to ensure that those identified with an order for compression stockings, ted | Completion Date: **02/10/2025**<br>Status: **APPROVED**<br>Date: **01/24/2025** |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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| F 0865<br><br>SS=D | Continued from page 16<br><br>§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.<br><br>§483.75(b) Program design and scope.<br>A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:<br><br>§483.75(b)(1) Address all systems of care and management practices;<br><br>§483.75(b)(2) Include clinical care, quality of life, and resident choice;<br><br>§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.<br><br>§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.<br><br>§483.75(f) Governance and leadership.<br>The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: | F 0865 | hose, and ACE wraps are being reviewed monthly during QAPI. The director of nursing/designee will educate all nursing staff on following orders as it relates to compression stockings, ted hose, and ace wraps.<br><br>The Administrator/designee will complete an initial whole house audit, then weekly audit x 4 weeks then monthly audit of all residents with compression stockings, ted house and Ace wrap orders. Then monthly thereafter with reporting through Quality Assurance and Process Improvement Committee for review and/or recommendation ongoing. | |

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| F 0865<br><br>SS=D | Continued from page 17<br><br>§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.<br><br>§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;<br>§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;<br><br>§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.<br><br>§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and<br><br>§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.<br><br>§483.75(h) Disclosure of information.<br>A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>§483.75(i) Sanctions. | F 0865 | | |

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| F 0865<br><br>SS=D | Continued from page 18<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by: | F 0865 | | |

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| F 0865<br><br>SS=D | Continued from page 19<br><br>Based on a review of facility documentation, cited deficiencies from previous surveys, review of plan of correction documentation, and staff interview, it was determined that the facility ' s Quality Assurance and Performance Improvement (QAPI) program failed to correct previously cited deficiencies. This has the potential to affect 16 of 140 residents.<br><br>Findings include:<br><br>Review of the facility policy Quality Assurance and Performance Improvement (QAPI) Program dated 8/13/24, indicated objectives of the QAPI program include providing a means to establish and implement performance improvement projects to correct identified negative or problematic indicators and to establish systems through which to monitor and evaluate corrective actions.<br><br>The facility ' s deficiencies and plan of correction for the State Survey and Certification (Department of Health) survey ending 3/22/24, revealed the facility | F 0865 | | |

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| F 0865<br><br>SS=D | Continued from page 20<br><br>developed a plan of correction that included quality assurance systems to ensure the facility maintained compliance with cited nursing home regulations.<br><br>Review of the plan of correction for the survey ending 3/22/24, revealed the following:<br>- All residents with compression stockings, ted hose, and ACE wraps (elastic bandages) will be audited for correct application. Identified deficient practice will be corrected upon notation with 1:1 education and return demonstration competency as indicated. To prevent future occurrence, nurses will receive education on maintenance and use of compression stockings, ted hose and ace wraps.<br>- Director of Nursing and/or designee will complete audits of maintenance and use of compression stockings, ted hose and ACE wraps three times per week for two weeks; weekly for two weeks; then monthly thereafter with reporting through Quality Assurance and Process Improvement Committee for review and/or recommendation ongoing.<br><br>The results of the current survey, ending 12/19/24, | F 0865 | | |

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| F 0865<br><br>SS=D | Continued from page 21<br><br>identified a repeated deficiency related to the improper placement and/or the lack of placement of elastic bandages for five of ten residents.<br><br>During the survey process the following was revealed:<br>- Resident R1 has his ACE wraps on both legs applied in the direction from the toes to the knees, and then reversing from the knees to the toes.<br>- Resident R2 had her ACE wrap on her left leg applied in the direction from the toes to the knee, and then reversing from the knee to the toes.<br>- Resident R3 did not have ACE wraps on.<br>- Resident R4 did not have ACE wraps on.<br>- Resident R5 did not have ACE wraps on.<br><br>During an interview on 12/19/24, at approximately 10:00 a.m. the Nursing Home Administrator and the Director of Nursing confirmed that facility failed to maintain an effective Quality Assurance Committee to ensure that the concerns related to the use of elastic bandages were identified, with the potential to affect 16 of 140 residents. | F 0865 | | |

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| F 0865<br><br>SS=D | Continued from page 22<br><br>42 CFR 483.75(a)(2)(h)(i) QAPI Program/Plan, Disclosure/Good Faith Attempt.<br><br>28 Pa. Code 201.18(e)(1) Management.<br><br>28 Pa. Code 201.18(e)(2)(3)(4) Management. | F 0865 | | |
| F 0880<br><br>SS=D | | F 0880 | | |

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| F 0880<br><br>SS=D | Continued from page 23<br><br>483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or<br>infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported; | F 0880 | Upon notation, Employee E2 was immediately removed from the unit to be educated by the Director of Nursing of the proper procedure for infection control protocols.<br><br>All residents that require blood glucose reading within the facility will be identified by the Director of Nursing/designee and 1:1 education will be provided by the Director of Nursing/designee to all nursing staff.<br><br>To prevent future occurrences, nurses will receive education by the Director of Nursing/designee on the proper infection control protocols as they relate to blood glucose readings.<br><br>Director of Nursing/designee will complete audits on each medication cart to ensure each cart has appropriate cleaning materials (disinfecting wipes containing bleach). The Director of Nursing/ designee will shadow the nurse as the task is being performed to ensure | Completion Date:<br>**02/10/2025**<br>Status:<br>**APPROVED**<br>Date:<br>**01/23/2025** |

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| F 0880<br><br>SS=D | Continued from page 24<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>This REQUIREMENT is not met as evidenced by: | F 0880 | proper infection control protocols are being followed at random with 4 Nurses 2x a week x 1 month; then monthly thereafter with reporting through Quality Assurance and Process Improvement Committee for review and/or recommendation ongoing. | |

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| F 0880 SS=D | Continued from page 25 | F 0880 | | |

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| F 0880<br><br>SS=D | Continued from page 26<br><br>Based on observation, manufacturer ' s instructions, and staff interviews, it was determined that the facility failed to consistently maintain an infection prevention and control program, which ensured proper cleaning and disinfecting of glucometers (a device used to test the amount of sugar in a person's blood) to prevent the potential for cross-contamination for one of three medication carts (Third Floor Cart Rooms 308-321).<br>.<br>Findings include:<br><br>Review of the guidance released by the U.S. Food and Drug Administration on 10/29/20, indicated that 70% ethanol solutions are not effective against viral bloodborne pathogens.<br><br>Review of the Centers for Disease Control and Prevention's document titled "Infection Prevention during Blood Glucose Monitoring and Insulin Administration" last reviewed 2/6/13, indicated that if blood glucose meters must be shared, the device | F 0880 | | |

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| F 0880<br><br>SS=D | Continued from page 27<br><br>should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents.<br><br>Review of the glucometer manufacturer's recommendation provided by the facility revealed under "Cleaning and Disinfecting Procedures for the Meter" indicated the meter must be disinfected between patient use by wiping it with an EPA (Environmental Protection Agency) approved disinfecting wipe.<br><br>During observation of a blood sugar check on 12/11/24, at 11:23 a.m. Licensed Practical Nurse (LPN) Employee E2 cleaned the glucometer after use with a 70% isopropyl alcohol pad. Observation at this time revealed disinfecting wipes containing bleach available on the nurse ' s station counter, approximately five feet from the medication cart.<br><br>During an interview on 12/11/24, at 2:47 p.m. LPN Employee E2 stated that she used alcohol pads to clean the glucometer because she did not have any | F 0880 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | (X5) COMPLETE DATE |
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| F 0880<br><br>SS=D | Continued from page 28<br><br>disinfecting wipes, and further stated was unaware that the use of alcohol wipes was unacceptable to clean a glucometer.<br><br>During an interview on 12/19/24, at approximately 10:00 a.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to consistently maintain an infection prevention and control program, which ensured proper cleaning and disinfecting of glucometers to prevent the potential for cross-contamination for one of three medication carts.<br><br>42 CFR 483.80(a)(1)(4)(f) Infection Prevention & Control.<br><br>28 Pa. Code §201.14(a) Responsibility of licensee.<br>28 Pa. Code §201.18(b)(1)(3)(e)(1) Management.<br>28 Pa. Code §201.20(c) Staff development.<br>28 Pa. Code §201.29(d) Resident rights.<br>28 Pa. Code §211.12(d)(1)(2)(3)(5) Nursing services. | F 0880 | | |

# Certified End Page

**CARNEGIE PARK POST ACUTE**

**STATE LICENSE NUMBER: 381502**

**SURVEY EXIT DATE: 12/19/2024**

**I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey**

Jeanne Parisi
*Deputy Secretary for Quality Assurance*

Debra L. Bogen MD
*Debra L. Bogen, MD, FAAP*
*Secretary of Health*

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

## PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY