

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
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NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE	STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220
STATE LICENSE NUMBER: 381502	

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F 0000	INITIAL COMMENT	F 0000		
F 0550 SS=E	Based on a Medicare/Medicaid Recertification Survey, Civil Rights Compliance Survey, State Licensure Survey and an Abbreviated survey in response to two complaints, completed on April 18, 2025, it was determined that Carnegie Park Post Acute was not in compliance with the 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 related to the health portion of the survey process.	F 0550		

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 0550 SS=E	Continued from page 1 483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 0550	Immediate Intervention: Staff for residents identified R67, R63, and R8 were notified that residents' rights were violated in the stated manor. Immediate counseling on resident rights to CNAs was provided. R67 and R63 we provided with immediate hygiene care and R8 was given hygiene care and lower body dressing provided. Identification of other residents who potentially can be affected: All residents residing in the building could potentially be affected by this violation of resident rights. Prevention of future occurrence: Educate all nursing staff on the call light response policy. Corrective Action to be monitored: DON/designee will complete the following audits. Call light response time will be monitored using an audit tool. DON/designee will interview 3 residents of each unit to determine if resident's rights are being violated.	Completion Date: 06/09/2025 Status: APPROVED Date: 05/12/2025

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F 0550 SS=E	Continued from page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:	F 0550	Audits for call-bell response times and interviews will be completed: 5 times per week for three weeks. Weekly for three weeks and then monthly for three months. QA Program: Call light response and maintaining Residents' rights will be added to Monthly QAPI meeting review.	

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F 0550 SS=E	Continued from page 3 Based on facility policy, resident interviews, observation, and staff interviews, it was determined that the facility failed to provide prompt assistance to meet residents care needs for three of fourteen residents who require care (Residents R63, R67, and R8). Findings included: Review of facility policy "Resident Rights" last reviewed 3/14/25, indicated employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. The "Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual," which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated that a BIMS (Brief Interview of Mental Status) is a brief screener that aids in detecting cognitive impairment. Scores from	F 0550		

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F 0550 SS=E	<p>Continued from page 4</p> <p>a BIMS assessment suggests the following distributions: 13 - 15: cognitively intact 8 - 12: moderately impaired 0 - 7: severe impairment</p> <p>Review of the clinical record revealed Resident R67 was originally admitted to the facility on 10/30/23.</p> <p>Review of the MDS dated 3/14/25, included diagnoses of coronary artery disease (reduced blood flow to the heart muscle) and heart failure (heart cannot keep up with its workload). Review of Section C: Cognitive Patterns, indicated, intact cognition with a BIMS Score of 15. Review of Section GG: 0130 Functional Abilities, indicated Resident R67 required partial/moderate assistance with toileting hygiene.</p> <p>During an interview with Resident R67 on 4/16/25, at 1:34 p.m., the following was stated: I have sat in a dirty brief for more than an hour. Last week was the most recent time it happened to me. It regularly</p>	F 0550		

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F 0550 SS=E	<p>Continued from page 5</p> <p>takes them an hour to answer the call lights no matter what you need.</p> <p>Review of the clinical record revealed Resident R63 was originally admitted to the facility on 5/6/24.</p> <p>Review of the MDS dated 2/28/25, included diagnoses of seizure disorder (abnormal electrical activity in the brain) and bipolar disorder (extreme mood swings). Review of Section C: Cognitive Patterns, indicated, intact cognition with a BIMS Score of 15. Review of Section GG: 0130 Functional Abilities, indicated Resident R63 was independent for toileting hygiene. Review of Section GG: 0170 Mobility toilet transfer, indicated Resident R63 requires supervision or touch assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently).</p> <p>During an interview with Resident R63 on 4/16/25, at 1:45 p.m., the following was stated: I can change</p>	F 0550		

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F 0550 SS=E	Continued from page 6 my brief myself, I need some help in the bathroom. I have had accidents in bed and need help getting things cleaned up. I can only do so much of it and the bed needs changed. Sometimes the staff come in and wake me up at 2:00 a.m. for me to change my brief so I don't have an accident, and I don't like them waking me at 2:00 a.m... Monday night (4/14/25) it happened to me again. I had an accident and had to wait for more than an hour for help to get things cleaned up. Waiting an hour or longer when you call for help is normal here. Review of the clinical record revealed Resident R8 was admitted to the facility on 3/28/25. Review of the MDS dated 4/4/25, included diagnoses of heart failure and sepsis (infection in the bloodstream). Review of Section C: Cognitive Patterns, indicated, intact cognition with a BIMS Score of 15. Review of Section GG: 0130 Functional Abilities, indicated Resident R8 required partial/moderate assistance for lower body dressing.	F 0550		

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F 0550 SS=E	Continued from page 7 During an interview and observation on 4/15/25, at 2:20 p.m., Resident R8 was observed dressed in a shirt and a brief. Resident R8 stated that he did not like not having any pants on. During an interview on 4/17/25, at approximately 9:00 a.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to provide an environment and care to promote dignity for each resident's quality of life for three of fourteen residents. 28 Pa. Code 211.12 (a)(c)(d)(4)(5) Nursing Services 28 Pa. Code 201.29 (j) Resident Rights	F 0550		
F 0577 SS=C		F 0577		

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F 0577 SS=C	Continued from page 8 483.10(g)(10)(11) Right to Survey Results/Advocate Agency Info §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by:	F 0577	Regional Director of Clinical Services educated the Administrator about the survey binder and its importance of locating the Survey results binder. Administrator will have large postings on every floor of the location the survey results binder that that floor. Administrator will do a weekly audit for 4 weeks to ensure that survey binder is updated.	Completion Date: 06/09/2025 Status: APPROVED Date: 05/16/2025

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F 0577 SS=C	Continued from page 9 Based on observation and staff interview, it was determined the facility failed to ensure the Department of Health most recent survey results were readily accessible to residents and visitors, for four of four locations (first floor lobby, nursing units ground, second and third floors). Findings Include: During an observation on 4/14/25, at 9:20 a.m. in the lobby, no survey result book could be located. During an observation on 4/14/25, at 9:25 a.m. on the second floor, no survey result book could be located. During an observation on 4/14/25, at 9:28 a.m. on the third floor, no survey result book could be located. During an observation on 4/14/25, at 9:32 a.m. on the ground floor, no survey result book could be located.	F 0577		

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F 0577 SS=C	Continued from page 10 During an interview on 2/12/25, at 9:25 a.m. the Nursing Home Administrator (NHA) confirmed the facility failed to ensure the Department of Health most recent survey results were readily accessible to residents and visitors for four of four locations, (first floor lobby, nursing units ground, first, and second floors). 28 Pa. Code 201.14(a) Responsibility of licensee.	F 0577		
F 0580 SS=D		F 0580		

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F 0580 SS=D	Continued from page 11 483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this	F 0580	Immediate Intervention: Resident and family were notified on all future appointments with dates and times including transportation times for pick up. Identification of other residents who potentially can be affected: All residents in the facility can be affected. Prevention of future occurrence: Education and policy review was provided to the scheduler on updating residents and families on upcoming appointments. The appointment scheduler/designee will print out all appointments and transportation for all residents in the facility. A copy will be given to the resident, and the family will be notified and documented in PCC. Corrective Action to be monitored: Audit tool created to assess resident and family notification of appointments and transportation. QA Program: Interview 3 residents	Completion Date: 06/09/2025 Status: APPROVED Date: 05/12/2025

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F 0580 SS=D	Continued from page 12 section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:	F 0580	with appointments daily for five days, then weekly for three weeks and monthly for three months. Notification of appointment compliance reviewed monthly at QAPI.	

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F 0580 SS=D	Continued from page 13 Based on review of facility policy, clinical records, and resident and staff interviews, it was determined that the facility failed to notify the resident representative of changes in appointment and transportation times for one of four residents (Resident R69). Findings include: Review of the facility policy, "Notification for Medical Appointments" dated 3/14/25, previously dated 8/13/24, indicated when a medical appointment is scheduled: - Document the appointment details in the resident's medical record. - Notify the responsible party at least 48 hours in advance, unless the appointment is emergent. - Use the resident's preferred communication method (e.g., phone, email, written notice). The notification to the responsible party should include: - Date and time of the appointment. - Name and specialty of the healthcare provider.	F 0580		

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F 0580 SS=D	Continued from page 14 - Purpose of the appointment. - Any special instructions or preparations required. Review of the clinical record indicated Resident R69 was admitted to the facility on 4/2/25. Review of Resident R69's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 4/6/25, included diagnoses diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and multiple fractures. Review of Resident R69's demographic profile indicated her son as her emergency contact and medical power-of-attorney. Review of a physician's progress note dated 4/8/25, at 6:54 p.m. indicated, "Spoke with patient's son regarding her appointment with plastics and the outcome of that appointment which was a referral to an orthopedic surgeon for her shoulder and otherwise no new orders. Patient's son voiced	F 0580		

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F 0580 SS=D	Continued from page 15 frustration over not being made aware of the appointment ahead of time which I passed along to administrative staff." During an interview on 4/16/25, at 2:15 p.m. Resident R69's son stated he was upset that his mother had gone to her appointment by herself soon after she was admitted. The son stated that it should be in the record that he is notified of all appointments and any time that Resident R69 was to be taken out of the facility, to which Resident R69 agreed. Resident R69's son stated that he had previously voiced concern to with facility administration, and was assured it would never happen again, but that "it had just happened again." Resident R69's son stated that he was going to accompany his mother to her appointment (4/15/25), with her traveling in wheelchair transportation. Resident R69's son said when he arrived at the facility, his mother had already departed, as there had been a change in the transportation time that he had not been informed of. Resident R69's son stated, I don't want my	F 0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
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F 0580 SS=D	Continued from page 16 [resident's age, greater than 90 years] old mother having to go anywhere by herself." During an interview on 4/18/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that this concern had been previously brought to facility administration and further confirmed that the facility failed to notify resident representative of changes in appointment and transportation times for one of four residents. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 201.29(d) Resident rights. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.	F 0580		
F 0584 SS=D		F 0584		

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F 0584 SS=D	Continued from page 17 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	The facility directed correct the deficient practice by removing the bed, mattress, and two treatment carts stored in the dining room. To prevent recurrence, staff have been reminded that dining rooms must not be used for storage, a new designated storage area has been established for extra equipment, and signage has been posted to reinforce this policy. Beginning June 9, 2025, the Unit Manager will conduct weekly inspections of all dining rooms for eight weeks, followed by monthly random checks. Any findings will be addressed immediately. The Administrator is responsible for ensuring the implementation and continued compliance with this plan.	Completion Date: 06/09/2025 Status: APPROVED Date: 05/12/2025

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F 0584 SS=D	Continued from page 18 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584		

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F 0584 SS=D	Continued from page 19 Based on review of facility policy , observations, and staff interviews it was determined that the facility failed to maintain a homelike environment in the facility (resident dining rooms) for one of four resident dining locations (first floor nursing unit). Findings include: A review of the facility "Homelike Environment Policy" dated 3/14/25, indicated residents are provided with a safe, clean, comfortable environment and encouraged to use their personal belongings to the extent possible. During an observation of the facility on 4/14/25, at 10:00 a.m., the following was revealed: First floor resident dining room had a bed, mattress, and two treatment carts stored in this location. During an interview on 4/14/25 at 10:32 a.m. Employee E1 unit manager confirmed the bed, mattress, and two treatment carts were stored in this	F 0584		

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F 0584 SS=D	Continued from page 20 location. During an interview on 4/15/25, at 10:30 a.m., the Nursing home Administrator and Director of Nursing confirmed that the facility failed to maintain the facility in a homelike environment for one of four resident dining locations (first floor nursing unit). Pa Code: 207.2 (a) Administrator's responsibility	F 0584		
F 0585 SS=C		F 0585		

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F 0585 SS=C	Continued from page 21 483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 0585	The facility will install secure, locked grievance boxes in each of the five locations where forms are provided (four dining rooms and the lobby). Each box will be clearly labeled and placed in a visible, accessible location. New signage will also be posted to inform residents and representatives that grievance/concern forms may be submitted anonymously through these boxes. A facility-wide check confirmed that no such boxes currently exist. Staff will be re-educated on the grievance policy, including the right to file anonymously, by the Social Services Director. The Social Services Department will check the boxes weekly to collect submissions and ensure functionality. Random monthly audits will continue thereafter. The Nursing Home Administrator is responsible for ensuring the implementation of this correction and compliance. Secure, locked grievance boxes will be installed in all five designated locations (four dining rooms and the	Completion Date: 06/09/2025 Status: APPROVED Date: 05/16/2025

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F 0585 SS=C	Continued from page 22 can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the	F 0585	lobby). Each box will be placed in a location that is visible and accessible to residents and representatives but positioned to maintain privacy, such as near unit entrances or in recessed wall areas obscured from direct staff oversight. Boxes will be clearly labeled and signage will be updated to inform residents and families that grievances may be submitted anonymously. On June 7, 2025, the Social Services Director provided an in-service training to the Administrator and Social Services staff responsible for grievance management. The training covered: The policy and resident rights regarding grievance filing The importance of maintaining anonymity Protocols for monitoring and responding to submissions Training documentation is retained in the education file. To ensure timely attention to	

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F 0585 SS=C	Continued from page 23 date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:	F 0585	grievances, the Social Services Department will check each box daily, beginning June 9, 2025. A log will be maintained to document daily checks and response actions. Additionally, monthly audits will be conducted to confirm: Each box remains secure and in proper working condition Signage is in place and clear Daily check logs are complete and up to date Audit results will be reviewed in the QAPI meeting each month to support continued compliance.	

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F 0585 SS=C	Continued from page 24 Based on review of facility policy, posted documents, observations, resident and staff interviews, it was determined that the facility failed to make certain grievance/concern forms can be filed anonymously for all residents and/or their representatives on five of five locations where grievance/complaint forms are provided (four nursing units and the lobby). Findings include: A review of the facility policy "Grievances/Complaints, Filing" last reviewed 3/14/25, indicated grievances and/or complaints may be submitted orally or in writing and may be filed anonymously. During an observation on 4/14/25 approximately 11:00 a.m. revealed no grievance boxes are available in the facility. Posted signage directs completed grievance/complaint forms be provided to social services, in the event the office is closed slide the document under the door.	F 0585		

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F 0585 SS=C	Continued from page 25 During an interview on 4/14/25, at 11:30 a.m. the Nursing Home Administrator confirmed that grievance boxes do not exist in the facility and confirmed the facility failed to make certain grievance/concern forms can be filed anonymously for all residents and/or their representatives on five of five locations where grievance/complaint forms are provided. 28 PA Code: 201.18(e)(4) Management. 28 PA Code: 201.29(a)(b)(c) Resident rights.	F 0585		
F 0677 SS=E		F 0677		

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F 0677 SS=E	Continued from page 26 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	Immediate Intervention: Call light box was inspected and found to have a burnt-out bulb and bulb was replaced immediately. R68 clothes were discovered in laundry and returned to R68 and nail care and hygiene were provided. R125 nail care provided. R08 lower body was dressed. R69 shower was provided. Identification of other residents who potentially can be affected: All residents were identified to potentially be affected. Prevention of further occurrence: Education to resident rights as it pertains to resident ADL care. Educate staff about ADL resident rights and call light system. Corrective Action to be monitored: Audit tool created and DON or designee to assess residents' hygiene and shower schedule for compliance. QA Program: 3 residents on each unit will be audited (to assess	Completion Date: 06/09/2025 Status: APPROVED Date: 05/16/2025

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F 0677 SS=E	Continued from page 27	F 0677	residents' hygiene and shower schedule for compliance) daily for five days, weekly for 3three weeks, and monthly for three months. The identification of non-compliance staff will result in a performance improvement plan with potential for corrective action and discipline. Results of shower compliance added to monthly QAPI.	

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F 0677 SS=E	Continued from page 28 Based on review of facility policy, facility records, and resident and staff interviews, it was determined that the facility failed to provide Activity of Daily Living (ADL) assistance for 15 of 22 residents as required (Resident R500, R501, R502, R503, R504, R505, R506, R507, R508, R509, R8, R68, R69, R125, and R243). Findings include: The facility policy "Call System, Residents" dated 3/14/25, indicated calls for assistance are answered as soon as possible, but no later than 5 minutes. Urgent requests for assistance are addressed immediately. The "Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual," which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated that a BIMS (Brief Interview of Mental Status) is a brief screener that	F 0677		

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F 0677 SS=E	Continued from page 29 aids in detecting cognitive impairment. Scores from a BIMS assessment suggests the following distributions: 13 - 15: cognitively intact 8 - 12: moderately impaired 0 - 7: severe impairment During a resident group interview on 4/14/25, at 1:30 p.m., ten of fourteen residents in attendance stated that they consistently wait one hour or longer for their call light to be responded to. (Residents R500, R501, R502, R503, R504, R505, R506, R507, R508, and R509). The residents in attendance expressed frustration regarding the wait time. The residents stated they have reported this at their resident council meeting. Review of the 2/26/25, resident council meeting minutes, under the nursing section, reveals complaints regarding the agency staff "they don't care." "If you need help no one answers, they are always on their phones."	F 0677		

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F 0677 SS=E	Continued from page 30 During an interview on 4/18/25, at 8:00 a.m. Director of Nursing (DON) confirmed the facility failed to make certain call bells were answered timely for ten of fourteen residents as required (Resident R500, R501, R502, R503, R504, R505, R506, R507, R508, and R509). During an interview on 4/14/25, at 12:59 p.m. Resident R243 stated that the call light response time is long. During an interview on 4/14/25, at 1:16 p.m. Resident R68 stated that he waits a long time for his clothes to be returned from being laundered. Stated staff keeps saying they will look, but he doesn't have his clothes back. Stated he is wearing facility clothing, and the pants are too tight. Observation at this time revealed long, unkempt fingernails and that Resident R68 was malodorous. During an observation on 4/14/25, at 1:20 p.m. Resident R125 was observed to have long, unkempt fingernails.	F 0677		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0677 SS=E	Continued from page 31 During an interview and observation on 4/15/25, at 2:20 p.m. Resident R8 was observed dressed in a shirt and a brief. Resident R8 stated that he did not like not having any pants on. During an interview on 4/15/25, at 2:36 p.m. Resident R69 stated that sometimes call lights can be long. Resident R69 stated that she has only had two showers since admission. Resident R69 stated she was given a bed bath, but that she prefers showers. Review of Resident R69's nurse aide task list indicated Resident R69 is scheduled to receive showers on Mondays and Thursdays, during evening shift. Review of Resident R69's bathing record (from 4/2/25, through 4/18/25) Resident R69 did not include a shower for the scheduled shower date of 4/7/25.	F 0677		

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NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
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F 0677 SS=E	Continued from page 32 During an interview on 4/18/25, the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide Activity of Daily Living (ADL) assistance for 15 of 22 residents. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services. 28 Pa Code: 201.29 (I)(o) Resident rights.	F 0677		
F 0680 SS=D		F 0680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
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F 0680 SS=D	Continued from page 33 483.24(c)(2)(i)(ii)(A)-(D) Qualifications of Activity Professional §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (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 (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 (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by:	F 0680	The facility will ensure that all activity assessments are reviewed and signed off by a licensed Occupational Therapist (OT) under the supervision of the Director of Rehabilitation. This temporary oversight measure will remain in place until our current Activities director has completed her licensure for the state. The Director of Rehab and RDCS will also provide guidance and ensure compliance with all regulatory standards for activity assessments and care planning. Staff involved in activity programming will be educated on the interim procedure and documentation expectations. Weekly reviews will be conducted by the Director of Rehab to confirm that all assessments are completed and signed appropriately.	Completion Date: 06/09/2025 Status: APPROVED Date: 05/12/2025

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F 0680 SS=D	Continued from page 34 Based on staff interviews and review of facility provided documentation, it was determined the facility failed to provide a qualified professional to direct the activities program as required for one of 12 months (3/3/25 through 4/14/25). Findings include: Review of the Activities Director job description required Qualifications "Certificates, Licenses, Registrations - Activity Director certificate." During an interview on 4/16/25, at 1:30 p.m. the Nursing Home Administrator (NHA) confirmed the facility failed to provide a qualified professional to direct the activities program for one of 12 months (3/3/25 through 4/14/25). 28 Pa Code 201.18(b)(3) Management. 28 Pa Code 201.18(e)(6) Management	F 0680		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 35 483.25 Quality of Care § 483.25 Quality of care 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. This REQUIREMENT is not met as evidenced by:	F 0684	Immediate Intervention: Surgeon was notified that dressing was removed. Orders received from surgeon for dressing. Immediate education for all nurses involved in dressing change was given. Education on following doctor's orders. How to Identify residents who can be affected: All residents can potentially be affected. Prevention of further occurrence: Immediate education for all nurses was started. All nursing staff will be trained in following doctors' orders using policy 7.1 medication administration. Corrective Action to monitor: Audit tool created to review staff compliance to review physician orders against completion. The wound nurse or designee will audit new wounds five days a week for three weeks, weekly for three weeks, and monthly for three months.	Completion Date: 06/09/2025 Status: APPROVED Date: 05/12/2025

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F 0684 SS=D	Continued from page 36	F 0684	QA Program: Identification of staff noncompliance will result in a performance improvement plan with potential for corrective action and discipline. Treatment compliance added to monthly QAPI for review.	

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F 0684 SS=D	<p>Continued from page 37</p> <p>Based on review of facility policies and documents, clinical records, and staff interviews, it was determined that the facility failed to provide care and services after hospitalization for one of three residents (Resident R68).</p> <p>Review of the clinical record indicated that Resident R68 was admitted to the facility on 3/19/25.</p> <p>Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 3/24/25, included diagnoses of anemia (too little iron in the body causing fatigue), chronic kidney disease (gradual loss of kidney function), and osteomyelitis (inflammation of bone or bone marrow, usually due to infection).</p> <p>Review of hospital discharge instructions dated 3/19/25, indicated for the facility to reinforce the dressing. No direction for changing the dressing was documented.</p> <p>Review of a progress note dated 3/20/25, at 9:07</p>	F 0684		

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F 0684 SS=D	Continued from page 38 a.m. indicated, "Pt (patient) has dressing intact to RLE (right lower extremity). Orders state to reinforce only, DO not change until F/U (follow-up) appointment in 2 weeks." Review of a progress note dated 3/21/25, at 2:44 p.m. indicated, "this nurse spoke with dr. office regarding right foot wound care. per md office do not remove dressing only reinforce until f/u pt in 1 1/2 weeks." Review of a physician's order dated 3/21/25, indicated, "DO NOT REMOVE RIGHT LEG DRESSING PER SURGEON. ONLY REINFORCE CALL OFFICE IF EXCESSIVE DRAINAGE." Review of a progress note dated 3/22/25 at 6:29 p.m. indicated, "The resident has an excessive amount of drainage to the right leg. He has orders in the system not to remove surgical dressing to reinforce and notify Dr of excessive drainage to site. Current CNA (nurse aide) stated she told [Unit	F 0684		

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F 0684 SS=D	Continued from page 39 Manager Employee E1 and Registered Nurse (RN) Employee E3] the Nurse cut off the white cast and wrapped the wound with the dirty ace wrap. And nothing was done. The dirty ace wrap has been on since Wednesday. Today on my shift 3-11 the wound has excessive drainage when checking the system the order states do not remove call reinforce dressing call the doctor for excessive drainage when reading off the order my hall partner called [Unit Manager Employee E1] if he was aware the cast had been removed since Wednesday he stated no, told her to tell [LPN Employee E4]. [RN Employee E3] told us that she had told both [Unit Manager Employee E1 and [RN Employee E3] the cast was cut off and that she wrapped the fresh dressing with a soiled bandage. He said [LPN Employee E5] to take pictures with her phone send it to him he was going to call, the Dr. As I was writing the note in the system. And calling the Dr. I have been asked to leave." During an interview on 4/18/24, at 10:40 a.m. Unit Manager Employee E1 confirmed that Resident	F 0684		

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F 0684 SS=D	Continued from page 40 R68's dressing was changed without an order. During an interview on 4/18/24, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide care and services after hospitalization for one of three residents. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.10(c)(d) Resident rights. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.	F 0684		
F 0730 SS=F		F 0730		

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F 0730 SS=F	Continued from page 41 483.35(d)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 0730	As a newly established company, we acknowledge this deficiency and view it as an opportunity to build a comprehensive and sustainable performance management system from the ground up. Recognizing the importance of staff development and regulatory compliance, we are committed to thoroughly evaluating all existing personnel and creating a robust framework for performance evaluations that supports both accountability and professional growth. To allow for a thoughtful and fair assessment of our current workforce, we have established a corrective action date of June 17, 2025. This extended timeline provides the necessary window to evaluate all nursing personnel, review existing training and evaluation protocols, and implement a standardized annual review system that aligns with each employee's hire date. During this period, Human Resources will work closely with the Director of Nursing and department heads to build a	Completion Date: 06/17/2025 Status: APPROVED Date: 05/16/2025

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F 0730 SS=F	Continued from page 42	F 0730	<p>tracking system that ensures timely evaluations moving forward. A performance evaluation template based on job-specific competencies and core values will be finalized and implemented by the corrective date.</p> <p>All nurse aide personnel files will be audited and updated, and a schedule will be created to complete all outstanding evaluations by June 17. Training for supervisors on conducting effective and compliant evaluations will also be completed prior to that date.</p> <p>Addendum to Ensure Compliance with 60-Day Requirement:</p> <p>The facility is committed to completing all outstanding performance evaluations for current nurse aide personnel by the regulatory deadline of June 17, 2025. Human Resources, in collaboration with the Director of Nursing, has begun auditing personnel files and will implement a tracking system by May 31 to support timely</p>	

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F 0730 SS=F	Continued from page 43	F 0730	completion. A standardized evaluation template will be finalized, and supervisors will receive in-service training to ensure evaluations are conducted appropriately. While every effort will be made to meet the June 17 target, if additional time is needed to ensure thorough and meaningful evaluations, the facility will continue working diligently to complete all evaluations as soon as possible. A long-term evaluation schedule based on hire dates will be implemented beginning July 1, 2025, to support ongoing compliance.	

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F 0730 SS=F	Continued from page 44 Based on review of personnel records and staff interview it was determined that the facility failed to provide nursing staff annual performance evaluations based on the date of hire for five of five nurse aides (Employees E11, E12, E13, E14, and E15). Findings include: Review of employee personnel files indicated no nursing staff annual performance evaluations. During an interview on 4/16/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed the facility failed to provide nursing staff annual performance evaluations based on the date of hire for five of five nurse aides. 28 Pa Code: 201.20 (a)(b)(c)(d) Staff development. 28 Pa Code: 201.14 (a) Responsibility of licensee.	F 0730		
F 0732 SS=A		F 0732		

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F 0732 SS=A	Continued from page 45 483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 0732	The administrator educated the Staffing Coordinator, who will be responsible for preparing and updating daily nurse staffing information using a standardized Excel sheet. This sheet will be printed and placed at the receptionist desk in a clearly marked and visible location each morning. The Staffing Coordinator will receive training on this new process, and a backup designee will be assigned to ensure coverage on weekends or in the coordinator's absence. The Nursing Home Administrator will conduct random weekly checks for four weeks to ensure staffing information is consistently posted and visible. Results will be reviewed with the Quality Assurance Committee.	Completion Date: 06/09/2025 Status: APPROVED Date: 05/12/2025

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F 0732 SS=A	Continued from page 46 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 0732			

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F 0732 SS=A	Continued from page 47 Based on an observation and staff interviews, it was determined that the facility failed to prominently display nurse staffing information for one of five days (4/14/25). Findings include: During an observation on 4/14/25, at 11:05 a.m. the Nursing Home Administrator (NHA) failed to locate the current nurse staffing information at the facility's receptionist desk. During an interview on 4/14/25, at 11:30 a.m. the NHA confirmed that the facility failed to prominently display nurse staffing information for one of five days (4/14/25), as required. 28 Pa. Code 211.12 (d)(1)(3)(4) Nursing services	F 0732		
F 0755 SS=D		F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0755 SS=D	Continued from page 48 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	Immediate Intervention: Immediate education for all nurses was given on medicating residents for pain and discomfort when pain is assessed. Education provided to all nurses by DON on medication availability in pyxis and process of obtaining new scripts. How to Identify residents who can be affected: All residents can potentially be affected Prevention of further occurrence: Education for medicating for pain and discomfort along with medication availability in pyxis and process of obtaining new scripts will be done in orientation. Corrective Action to be monitored: DON/designee will audit documented pain scale against pain medications administered of 5 residents on each unit daily for five days, then weekly for three weeks, then monthly for three months. QA Program: Performance	Completion Date: 06/09/2025 Status: APPROVED Date: 05/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
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F 0755 SS=D	Continued from page 49 This REQUIREMENT is not met as evidenced by:	F 0755	improvement plan using Plan do Study Act and root cause analysis for proper medication administration for PRN pain medication administration and availability of routine medications to be presented monthly at QAPI.	

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F 0755 SS=D	Continued from page 50 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to implement procedures to ensure availability of prescribed medications for one of five residents (Residents R244). Findings include: Review of the facility policy, "Pharmacy Services Overview" dated 3/14/25, the facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications and biologicals, and the services of a licensed consultant pharmacist." Review of the clinical record indicated Resident R244 was admitted to the facility on 4/11/25. Review of the facility diagnosis list included chronic obstructive pulmonary disease (COPD - a group of progressive lung disorders characterized by increasing breathlessness), spinal stenosis (a	F 0755		

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F 0755 SS=D	Continued from page 51 narrowing of the spaces within the spine, which causes pain and weakness), and chronic pain syndrome. Review of a physician's orders dated 4/11/25, indicated Resident R244 was to receive oxycodone (a narcotic pain medication to treat moderate to severe pain) 10 mg (milligrams), 1.5 tablet (15 mg) by mouth every four hours as needed for severe pain. Review of a physician's orders dated 4/11/25, indicated Resident R244 was to receive Methocarbamol (muscle relaxant that works by calming overactive nerves in the body) 1000 mg four times a day for muscle spasms for ten days. Review of a physician's orders dated 4/11/25, indicated Resident R244 was to receive Ketorolac Tromethamine (nonsteroidal anti-inflammatory drug (NSAID) specifically recommended for moderate to severe pain) 10 mg, one tablet by mouth four times a day.	F 0755		

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F 0755 SS=D	Continued from page 52 Review of Resident R244 ' s documented pain levels indicated the following levels based on a zero to ten scale with zero being no pain and ten being the worst: 4/12/25, at 9:10 a.m. - "8" 4/12/25, at 5:09 p.m. - "7" 4/12/25, at 9:38 p.m. - "8" 4/13/25, at 5:59 a.m. - "7" 4/13/25, at 12:22 p.m. - "9" 4/14/25, at 9:10 a.m. - "8" 4/14/25, at 8:38 a.m. - "10" Review of Resident R1's Medication Administration Record (MAR) for April 2025, indicated: 4/11/25: No documentation of oxycodone provided. 4/11/25: Ketorolac, documented as "9" ("9" is code for order Other/See Nurse Notes). The pain level noted with this scheduled administration was "10." Review of the associated progress note dated 4/11/25, at 11:07 p.m. indicated, "per [physician]	F 0755		

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F 0755 SS=D	Continued from page 53 ok to give when arrives from pharmacy. 4/12/25: Methocarbamol, documented as "9". Review of the associated progress note dated 4/12/25, at 11:55 a.m. indicated, indicated that the medication was on order from the pharmacy. Review of an admission progress note dated 4/11/2025, at 10:13 p.m. indicated, "explained to us she has several bone fractures on the right side of her lumbar spine and 8 pins and 8 rods on left side of spine. c/o pain of 10." Review of the facility provided inventory for the automated medication dispensing machine included oxycodone 5 and 10 mg tablets and Methocarbamol 500 mg tablets. During a follow-up communication on 4/18/25, at 1:30 p.m. the Director of Nursing was made aware that the facility failed to implement procedures to ensure availability of prescribed medications for one of five residents.	F 0755		

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F 0755 SS=D	Continued from page 54 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0755			
F 0761 SS=E		F 0761			

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F 0761 SS=E	Continued from page 55 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	Immediate Intervention: Treatment cart was used for education and stored on units in common areas. The treatment cart was discarded, and its contents were destroyed. How to identify residents who can be affected: No further residents can be affected because the cart was removed, and contents were destroyed. Prevention of further occurrence: facility assessment to determine if there are any other carts that need labeled or disposed. Corrective Action to be monitored: DON or designee to do weekly checks around the facility for carts and its contents being labeled, dated, and locked appropriately for one month and monthly for three months. QA Program: Performance Improvement plan added to monthly QAPI meetings to evaluate employee education progress.	Completion Date: 06/09/2025 Status: APPROVED Date: 05/16/2025

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F 0761 SS=E	<p>Continued from page 56</p> <p>Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to make certain that medications were properly stored and/or disposed of in the unused dining room on the first floor.</p> <p>Findings include:</p> <p>Review of facility policy "Storage of Medications" dated 3/14/25, stated that if the facility has discontinued, outdated, or deteriorated medications or biologicals, should be returned to the dispensing pharmacy or destroyed.</p> <p>During an observation of the first-floor dining room(unused) on 4/14/24, at 9:35 a.m. the following was observed: -(1) box of Midline blood glucose test strips expiring 7/8/23. -(1) adult manual resuscitator expiring 7/8/23</p> <p>During an interview on 4/14/25, at 10:32 a.m. Unit Manager Employee E1 confirmed the above</p>	F 0761		

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F 0761 SS=E	Continued from page 57 observations. During in observation of the ground floor clean utility room on 4/14/25, at 1:14 p.m. the door was noted to have a keypad lock, but the door was not closed. Within that room, an unlocked treatment cart was observed with the following items inside: -(3) open, partially used tubes of medical honey ointment, without names, date of opening, and allowed to commingle without being individually bagged. -(5) wound dressing packages, with an expiration date of 07/2022. During an interview on 4/14/25, at 1:20 p.m. Licensed Practical Nurse Employee E5 confirmed the above observations. During an interview on 4/15/25, at approximately 10:30 a.m. the Director of Nursing confirmed that the facility failed to make certain that medications were properly stored and/or disposed of in the unused dining room on the first floor.	F 0761		

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F 0761 SS=E	Continued from page 58 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 28 Pa. Code: 211.9 (a)(1) Pharmacy services. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.	F 0761		
F 0803 SS=E		F 0803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
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F 0803 SS=E	Continued from page 59 483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by:	F 0803	the Dietary Director will ensure all menu changes are reviewed and approved at least 24 hours in advance by the Dietitian and Administrator. To notify residents in a simple and effective manner, the facility will implement a "Daily Menu Notice Board" in the facility, updated each morning by dietary staff. Any changes to the published menu will be clearly highlighted, and a brief explanation will be included. In addition, nursing aides will verbally inform residents of any substitutions at mealtime. To address errors in food preferences, the Dietary Services Director and Dietitian will jointly audit all resident food tickets for accuracy by June 9, 2025, and ensure corrections are entered into the dietary software. Staff responsible for tray preparation will receive re-training on reviewing food tickets and adhering to standing orders. A weekly audit of at least 10 meal trays will be conducted for 8 weeks to confirm compliance with resident preferences. The Administrator will monitor audit	Completion Date: 06/09/2025 Status: APPROVED Date: 05/12/2025

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F 0803 SS=E	Continued from page 60	F 0803	results and ensure follow-up for any deviations.	

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F 0803 SS=E	Continued from page 61 Based on a review of facility policies, the Four-week Spring Summer (SS) cycle menu diet extension sheets, and staff interviews it was determined that the facility failed to follow a preplanned cycle menu (lunch meal on 4/14/25), as required and failed to provide resident's their preferences and standing order food choices (Residents R47 and R90). Findings include: Review of the facility policy "Menus," last reviewed on 3/14/25, with a previous review date of 8/13/24, indicated that menus are developed and prepared to meet resident choices while following established national guidelines for nutritional adequacy. Review of the facility policy "Resident Food Preferences," last reviewed on 3/14/25, with a previous review date of 8/13/24, indicated individual food preferences are assessed upon admission, and communicated to the interdisciplinary team. The facility has documented food preferences and	F 0803		

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F 0803 SS=E	<p>Continued from page 62</p> <p>dislikes on each resident food ticket.</p> <p>During a resident group interview on 4/14/25, at 1:30 p.m., the resident consensus identified that the facility had provided pot pie for lunch on 4/14/25, however, they were expecting chicken tenders which had been on the menu.</p> <p>During an observation of the posted menu for 4/14/25, indicated chicken tenders while the posting on the wall indicated that the pot pie had been substituted however, the residents were not made aware of the change.</p> <p>During an interview on 4/15/25, at 12:35 p.m., the Nursing Home Administrator confirmed that the facility failed to notify the residents of the menu change prior to the date, as required.</p> <p>During an observation on 4/15/25, at 8:20 a.m., Resident R 47 stated that she was provided toast and a bagel and one cup of coffee. Resident R47 stated that she has a preference indicated on her</p>	F 0803		

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F 0803 SS=E	Continued from page 63 ticket. The ticket shows standing orders of two cups of coffee, orange juice and a boiled egg. Resident R47 had no protein on her breakfast tray. During an observation on 4/15/25, at 8:30 a.m., Resident R90 was provided a scrambled egg. Observation of her standing orders indicated a boiled egg and her dislike is identified as a scrambled egg. The resident stated that they never give her a boiled egg and you "never know what you're gonna get". During an interview on 4/15/25, at 1:20 p.m., the Dietary Services Director Employee E6 confirmed that he has made menu changes "to see what the residents like". The residents have dislikes and preferences and "I could track them easier in a different computer system so if they don't get what they want, I cannot track there preferences". He was shown the incorrect tickets which indicated standing orders and preferences. No comment was made.	F 0803		

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F 0803 SS=E	Continued from page 64 During an interview on 4/18/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to follow a preplanned cycle menu and failed to provide resident's their preferences and standing order food choices. Pa Code: 211.6(a) Dietary services. Pa Code: 201.14(a) Responsibility of licensee	F 0803		
F 0919 SS=D	483.90(g)(1)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by:	F 0919	This error was corrected within the survey time and the deficient practice has been fixed. Staff will be re-educated by DON on the importance of promptly responding to call bells and reporting any malfunctions immediately. Weekly maintenance checks of the call system will be conducted for eight weeks, with findings reported to the QAPI committee. The DON or designee will complete the weekly checks	Completion Date: 06/09/2025 Status: APPROVED Date: 05/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0919 SS=D	<p>Continued from page 65</p> <p>Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to ensure that the call bell system was in full working order for one of four nursing units (Second Floor Nursing unit).</p> <p>Findings include:</p> <p>Review of the facility policy "Call System, Residents" 3/14/25, indicated that the call system communication will be audible and visual and the resident call system will be functional at all times.</p> <p>During an observation of the Second Floor Nursing Unit, central call bells identified in the A, B, and C halls did not illuminate when resident call bells in their rooms of each hall had been activated.</p> <p>During an interview on 4/15/25, at 9:10 a.m., the Director of Nursing confirmed that the central call bells were not functioning to provide unobstructed visual communication of which hall the call bell was coming from due to the ceiling bulkhead.</p>	F 0919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
STATE LICENSE NUMBER: 381502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0919 SS=D	Continued from page 66 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18 (b) (1) Management.	F 0919		
F 0921 SS=D		F 0921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
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F 0921 SS=D	Continued from page 67 483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 0921	The facility noted the incorrect practices and the situation was addressed immediately. Maintenance staff began repairs as soon as the damage was discovered, and both residents were temporarily relocated to another room to ensure their safety and comfort during the repair process. Their personal belongings were cleaned and restored, and the room was returned to a clean, functional condition upon completion of the repairs. To prevent recurrence, all maintenance projects involving occupied resident rooms will now require advance coordination with nursing and housekeeping staff to ensure resident relocation and item protection prior to work beginning. The TELS system will be the means by which all maintenance repairs are used, including confirming that rooms are vacated and resident property is secured. On April 17, 2025, the Maintenance Director provided in-service	Completion Date: 06/09/2025 Status: APPROVED Date: 05/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
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F 0921 SS=D	Continued from page 68	F 0921	education to all maintenance staff on the new protocol for repairs in occupied resident rooms, including the requirement for coordination with nursing and housekeeping, proper resident relocation, and protection of personal items. All work orders will continue to be processed through the TELS system, which now includes confirmation that rooms are vacated and belongings secured prior to any work. To ensure compliance, the Administrator or designee will conduct weekly audits 2 random maintenance work orders for eight weeks beginning April 21, 2025. Audit results will be reviewed during QAPI meetings, with monthly spot checks continuing thereafter as part of the facility's environmental safety program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
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F 0921 SS=D	Continued from page 69 Based on observation and staff interview, it was determined that the facility failed to ensure a safe, functional and clean environment for two of 33 residents of the Third floor B wing nursing unit (Resident R99 and R112). Findings include: During an observation on 4/16/25, at 8:50 a.m., of the Third Floor Nursing Unit, two maintenance workers were observed exiting Resident R99 and R112's resident room. Upon entering the resident room, a four foot by four foot area (approximately) wall behind Resident R99's bed had been removed exposing wires and insulation. When asked, Maintenance Director Employee E7 stated that the wall had "pulled away, from the television being too heavy" and it needed repaired. Resident R99 and R112's belongings were scattered all over the room allowing debris to fall onto them and into their personal items. During an interview on 4/16/25, at 9:25 a.m., the	F 0921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 04/18/2025
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F 0921 SS=D	Continued from page 70 Nursing Home Administrator confirmed that the facility failed to provide a safe, functional resident room for Residents R99 and R112. 28 Pa. Code: 207.2(a) Administrator's responsibility.	F 0921			
F 0941 SS=C		F 0941			

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F 0941 SS=C	Continued from page 71 483.95(a) Communication Training §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. This REQUIREMENT is not met as evidenced by:	F 0941	Immediate Intervention: All nursing staff were provided with communication training on the electronic platform. How to identify residents who can be affected: All employees can be affected. Prevention of further occurrence: Nurse educator reviewed training platform and discovered that 0941 was not uploaded to the training platform. Effective communication has since been uploaded, and employees have been given 30 days to complete training. By June 6, 2025, all employees will have 0941 training completed. Corrective action required: nurse educator to review all staff training compliance monthly and report to DON delinquent staff. DON will pursue corrective action and discipline for employees who are non-compliant. QA Program: Nurse educator will	Completion Date: 06/09/2025 Status: APPROVED Date: 05/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
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F 0941 SS=C	Continued from page 72	F 0941	report on staff compliance of staff education monthly at QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
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F 0941 SS=C	Continued from page 73 Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on Effective Communication for seven of eight staff members (Employee E11, E12, E13, E14, E15, E16, and E19). Findings include: Review of the facility policy, "In-Service Training, All Staff" most recently reviewed 3/14/25, indicated all personnel will receive education and training related to resident care. Required training topics include the following: a. Effective communication with residents and family (direct care staff); b. Resident rights and responsibilities; c. Preventing abuse, neglect, exploitation, and misappropriation of resident property including; d. Elements and goals of the facility QAPI program; e. The infection prevention and control program standards, policies and procedures;	F 0941		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
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F 0941 SS=C	Continued from page 74 f. Behavioral health; and g. The compliance and ethics program standards, policies and procedures. (Compliance and ethics training is conducted annually when this organization is operating five or more facilities.) Review of facility provided documents and training records revealed the following staff members did not have documented training on effective communication: Nurse Aide Employee E11 had a hire date of 3/26/23, failed to have Effective Communication in-service education between 3/26/24, and 3/26/25. Nurse Aide Employee E12 had a hire date of 3/8/22, failed to have Effective Communication in-service education between 3/8/24, and 3/8/25. Nurse Aide Employee E13 had a hire date of 3/14/05, failed to have Effective Communication in-service education between 3/14/24, and 3/14/25.	F 0941		

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F 0941 SS=C	Continued from page 75 Nurse Aide Employee E14 had a hire date of 1/12/95, failed to have Effective Communication in-service education between 1/12/24, and 1/12/25. Nurse Aide Employee E15 had a hire date of 4/14/14, failed to have Effective Communication in-service education between 4/14/24, and 4/14/25. Registered Nurse Employee E16 had a hire date of 4/15/22, failed to have Effective Communication in-service education between 4/15/24, and 4/15/25. Registered Nurse Employee E19 had a hire date of 3/12/07, failed to have Effective Communication in-service education between 3/12/24, and 3/12/25. During an interview on 4/18/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on Effective Communication for of seven of eight staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee.	F 0941		

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F 0941 SS=C	Continued from page 76 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.	F 0941		
F 0942 SS=C		F 0942		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
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F 0942 SS=C	Continued from page 77 483.95(b) Resident Rights Training §483.95(b) Resident's rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively. This REQUIREMENT is not met as evidenced by:	F 0942	All nursing staff were provided with Resident Rights training on the electronic platform. How to identify residents who can be affected: All employees can be affected. Prevention of further occurrence: Nurse educator reviewed training platform and discovered that 0941 was not uploaded to the training platform. Resident Rights has since been uploaded, and employees have been given 30 days to complete training. By June 6, 2025, all employees will have 0942 training completed. Corrective action required: nurse educator to review all staff training compliance monthly and report to DON delinquent staff. DON will pursue corrective action and discipline for employees who are non-compliant. QA Program: Nurse educator will report on staff compliance of staff	Completion Date: 06/09/2025 Status: APPROVED Date: 05/12/2025

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F 0942 SS=C	Continued from page 78	F 0942	education monthly at QAPI.		

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F 0942 SS=C	Continued from page 79 Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on Resident Rights for eight of ten staff members (Employee E11, E12, E13, E14, E15, E16, E17, E19, and E20). Findings include: Review of the facility policy, "In-Service Training, All Staff" most recently reviewed 3/14/25, indicated all personnel will receive education and training related to resident care. Required training topics include the following: a. Effective communication with residents and family (direct care staff); b. Resident rights and responsibilities; c. Preventing abuse, neglect, exploitation, and misappropriation of resident property including; d. Elements and goals of the facility QAPI program; e. The infection prevention and control program standards, policies and procedures;	F 0942		

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F 0942 SS=C	Continued from page 80 f. Behavioral health; and g. The compliance and ethics program standards, policies and procedures. (Compliance and ethics training is conducted annually when this organization is operating five or more facilities.) Review of facility provided documents and training records revealed the following staff members did not have documented training on Resident Rights; Nurse Aide Employee E11 had a hire date of 3/26/23, failed to have Resident Rights in-service education between 3/26/24, and 3/26/25. Nurse Aide Employee E13 had a hire date of 3/14/05, failed to have Resident Rights in-service education between 3/14/24, and 3/14/25. Nurse Aide Employee E14 had a hire date of 1/12/95, failed to have Resident Rights in-service education between 1/12/24, and 1/12/25. Nurse Aide Employee E15 had a hire date of	F 0942		

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F 0942 SS=C	Continued from page 81 4/14/14, failed to have Resident Rights in-service education between 4/14/24, and 4/14/25. Registered Nurse Employee E16 had a hire date of 4/15/22, failed to have Resident Rights in-service education between 4/15/24, and 4/15/25. Medical Records Employee E17 had a hire date of 4/6/10, failed to have Resident Rights in-service education between 4/6/24, and 4/6/25. Registered Nurse Employee E19 had a hire date of 3/12/07, failed to have Resident Rights in-service education between 3/12/24, and 3/12/25. Dietary Employee E20 had a hire date of 4/6/17, failed to have Resident Rights in-service education between 4/6/24, and 4/6/25. During an interview on 4/18/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training	F 0942		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
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F 0942 SS=C	Continued from page 82 on Resident Rights for eight of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.	F 0942		
F 0943 SS=D		F 0943		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
STATE LICENSE NUMBER: 381502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0943 SS=D	Continued from page 83 483.95(c)(1)-(3) Abuse, Neglect, and Exploitation Training §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by:	F 0943	Immediate Intervention: All nursing staff were provided with Abuse/Neglect and Exploitation on the electronic platform. How to identify residents who can be affected: All employees can be affected. Prevention of further occurrence: Abuse and Neglect is part of annual training on the electronic platform. Nurse Educator has identified employees who need to complete Abuse/Neglect education. Employees have been given 30 days to complete training. By June 6, 2025, all employees will have 0943 training completed. Corrective action required: Nurse educator to review all staff training compliance monthly and report to DON delinquent staff. DON will pursue corrective action and discipline for employees who are non-compliant. QA Program: Nurse educator will	Completion Date: 06/09/2025 Status: APPROVED Date: 05/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502			STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
F 0943 SS=D	Continued from page 84	F 0943	report on staff compliance of staff education monthly at QAPI.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0943 SS=D	Continued from page 85 Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on Prevention of Abuse and Neglect for one of ten staff members (Employee E18). Findings include: Review of the facility policy, "In-Service Training, All Staff" most recently reviewed 3/14/25, indicated all personnel will receive education and training related to resident care. Required training topics include the following: a. Effective communication with residents and family (direct care staff); b. Resident rights and responsibilities; c. Preventing abuse, neglect, exploitation, and misappropriation of resident property including: d. Elements and goals of the facility QAPI program; e. The infection prevention and control program standards, policies and procedures; f. Behavioral health; and g. The compliance and	F 0943		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0943 SS=D	Continued from page 86 ethics program standards, policies and procedures. (Compliance and ethics training is conducted annually when this organization is operating five or more facilities.) Review of facility provided documents and training records revealed the following staff members did not have documented training on Prevention of Abuse and Neglect: Therapy Employee E18 had a hire date of 2/9/09, failed to have Prevention of Abuse and Neglect in-service education between 2/9/24, and 2/9/25. During an interview on 4/18/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on Prevention of Abuse and Neglect for one of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management.	F 0943		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
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NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502	STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0943 SS=D	Continued from page 87 28 Pa Code: 201.20 (a)(c) Staff development.	F 0943		
F 0944 SS=C		F 0944		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0944 SS=C	Continued from page 88 483.95(d) QAPI Training §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by:	F 0944	Immediate Intervention: All nursing staff were provided with QAPI training on the electronic platform. How to identify residents who can be affected: All employees can be affected. Prevention of further occurrence: Nurse educator reviewed training platform and discovered that 0944 was not uploaded to the training platform. QAPI training has since been uploaded, and employees have been given 30 days to complete training. By June 6, 2025, all employees will have 0944 training completed. Corrective action required: nurse educator to review all staff training compliance monthly and report to DON delinquent staff. DON will pursue corrective action and discipline for employees who are non-compliant. QA Program: Nurse educator will report on staff compliance of staff	Completion Date: 06/09/2025 Status: APPROVED Date: 05/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
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NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502	STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0944 SS=C	Continued from page 89	F 0944	education monthly at QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
STATE LICENSE NUMBER: 381502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0944 SS=C	Continued from page 90 Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on Quality Assurance and Performance Improvement (QAPI) for ten of ten staff members (Employee E11, E12, E13, E14, E15, E16, E17, E18, E19, and E20). Findings include: Review of the facility policy, "In-Service Training, All Staff" most recently reviewed 3/14/25, indicated all personnel will receive education and training related to resident care. Required training topics include the following: a. Effective communication with residents and family (direct care staff); b. Resident rights and responsibilities; c. Preventing abuse, neglect, exploitation, and misappropriation of resident property including: d. Elements and goals of the facility QAPI program; e. The infection prevention and control program	F 0944		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0944 SS=C	Continued from page 91 standards, policies and procedures; f. Behavioral health; and g. The compliance and ethics program standards, policies and procedures. (Compliance and ethics training is conducted annually when this organization is operating five or more facilities.) Review of facility provided documents and training records revealed the following staff members did not have documented training on the QAPI program: Nurse Aide Employee E11 had a hire date of 3/26/23, failed to have QAPI in-service education between 3/26/24, and 3/26/25. Nurse Aide Employee E12 had a hire date of 3/8/22, failed to have QAPI in-service education between 3/8/24, and 3/8/25. Nurse Aide Employee E13 had a hire date of 3/14/05, failed to have QAPI in-service education between 3/14/24, and 3/14/25.	F 0944		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0944 SS=C	Continued from page 92 Nurse Aide Employee E14 had a hire date of 1/12/95, failed to have QAPI in-service education between 1/12/24, and 1/12/25. Nurse Aide Employee E15 had a hire date of 4/14/14, failed to have QAPI in-service education between 4/14/24, and 4/14/25. Registered Nurse Employee E16 had a hire date of 4/15/22, failed to have QAPI in-service education between 4/15/24, and 4/15/25. Medical Records Employee E17 had a hire date of 4/6/10, failed to have QAPI in-service education between 4/6/24, and 4/6/25. Therapy Employee E18 had a hire date of 2/9/09, failed to have QAPI in-service education between 2/9/24, and 2/9/25. Registered Nurse Employee E19 had a hire date of 3/12/07, failed to have QAPI in-service education between 3/12/24, and 3/12/25.	F 0944		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
STATE LICENSE NUMBER: 381502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0944 SS=C	Continued from page 93 Dietary Employee E20 had a hire date of 4/6/17, failed to have QAPI in-service education between 4/6/23, and 4/6/25. During an interview on 4/18/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on QAPI for ten of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.	F 0944		
F 0945 SS=E		F 0945		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
STATE LICENSE NUMBER: 381502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0945 SS=E	Continued from page 94 483.95(e) Infection Control Training §483.95(e) Infection control. A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at §483.80(a)(2). This REQUIREMENT is not met as evidenced by:	F 0945	Immediate Intervention: All nursing staff were provided with Infection Control training on the electronic platform. How to identify residents who can be affected: All employees can be affected. Prevention of further occurrence: Nurse educator reviewed the training platform and discovered that 0945 was not uploaded to the training platform. Infection Control training has since been uploaded, and employees have been given 30 days to complete training. By June 6, 2025, all employees will have 0945 training completed. Corrective action required: nurse educator to review all staff training compliance monthly and report to DON delinquent staff. DON will pursue corrective action and discipline for employees who are non-compliant. QA Program: Nurse educator will	Completion Date: 06/09/2025 Status: APPROVED Date: 05/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502			STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
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F 0945 SS=E	Continued from page 95	F 0945	report on staff compliance of staff education monthly at QAPI.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
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F 0945 SS=E	Continued from page 96 Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on Infection Control for seven of ten staff members (Employee E11, E13, E14, E15, E16, E17, and E18). Findings include: Review of the facility policy, "In-Service Training, All Staff" most recently reviewed 3/14/25, indicated all personnel will receive education and training related to resident care. Required training topics include the following: a. Effective communication with residents and family (direct care staff); b. Resident rights and responsibilities; c. Preventing abuse, neglect, exploitation, and misappropriation of resident property including; d. Elements and goals of the facility QAPI program; e. The infection prevention and control program standards, policies and procedures;	F 0945		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
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F 0945 SS=E	Continued from page 97 f. Behavioral health; and g. The compliance and ethics program standards, policies and procedures. (Compliance and ethics training is conducted annually when this organization is operating five or more facilities.) Review of facility provided documents and training records revealed the following staff members did not have documented training on Infection Control: Nurse Aide Employee E11 had a hire date of 3/26/23, failed to have Infection Control in-service education between 3/26/24, and 3/26/25. Nurse Aide Employee E13 had a hire date of 3/14/05, failed to have Infection Control in-service education between 3/14/24, and 3/14/25. Nurse Aide Employee E14 had a hire date of 1/12/95, failed to have Infection Control in-service education between 1/12/24, and 1/12/25. Nurse Aide Employee E15 had a hire date of	F 0945		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0945 SS=E	Continued from page 98 4/14/14, failed to have Infection Control in-service education between 4/14/24, and 4/14/25. Registered Nurse Employee E16 had a hire date of 4/15/22, failed to have Infection Control in-service education between 4/15/24, and 4/15/25. Medical Records Employee E17 had a hire date of 4/6/10, failed to have Infection Control in-service education between 4/6/24, and 4/6/25. Therapy Employee E18 had a hire date of 2/9/09, failed to have Infection Control in-service education between 2/9/24, and 2/9/25. During an interview on 4/18/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on Infection Control for seven of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management.	F 0945		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502			STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
F 0945 SS=E	Continued from page 99 28 Pa Code: 201.20 (a)(c) Staff development.	F 0945			
F 0946 SS=B		F 0946			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
STATE LICENSE NUMBER: 381502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0946 SS=B	Continued from page 100 483.95(f)(1)(2) Compliance and Ethics Training §483.95(f) Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at §483.85- §483.95(f)(1) An effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program. §483.95(f)(2) Annual training if the operating organization operates five or more facilities. This REQUIREMENT is not met as evidenced by:	F 0946	Immediate Intervention: All nursing staff were provided with Compliance and Ethics training on the electronic platform. How to identify residents who can be affected: All employees can be affected. Prevention of further occurrence: Nurse educator reviewed the training platform and Compliance and Ethics training discovered that 0946 was not uploaded to the training platform. has since been uploaded, and employees have been given 30 days to complete training. By June 6, 2025, all employees will have 0946 training completed. Corrective action required: nurse educator to review all staff training compliance monthly and report to DON delinquent staff. DON will pursue corrective action and discipline for employees who are non-compliant. QA Program: Nurse educator will	Completion Date: 06/09/2025 Status: APPROVED Date: 05/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
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NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502	STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0946 SS=B	Continued from page 101	F 0946	report on staff compliance of staff education monthly at QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0946 SS=B	Continued from page 102 Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on Compliance and Ethics for four of ten staff members (Employee E11, E15, E16, and E19). Findings include: Review of the facility policy, "In-Service Training, All Staff" most recently reviewed 3/14/25, indicated all personnel will receive education and training related to resident care. Required training topics include the following: a. Effective communication with residents and family (direct care staff); b. Resident rights and responsibilities; c. Preventing abuse, neglect, exploitation, and misappropriation of resident property including: d. Elements and goals of the facility QAPI program; e. The infection prevention and control program standards, policies and procedures; f. Behavioral health; and g. The compliance and	F 0946		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0946 SS=B	Continued from page 103 ethics program standards, policies and procedures. (Compliance and ethics training is conducted annually when this organization is operating five or more facilities.) Review of facility provided documents and training records revealed the following staff members did not have documented training on Compliance and Ethics: Nurse Aide Employee E11 had a hire date of 3/26/23, failed to have Compliance and Ethics in-service education between 3/26/24, and 3/26/25. Nurse Aide Employee E15 had a hire date of 4/14/14, failed to have Compliance and Ethics in-service education between 4/14/24, and 4/14/25. Registered Nurse Employee E16 had a hire date of 4/15/22, failed to have Compliance and Ethics in-service education between 4/15/24, and 4/15/25. Registered Nurse Employee E19 had a hire date of	F 0946		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
STATE LICENSE NUMBER: 381502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0946 SS=B	Continued from page 104 3/12/07, failed to have Compliance and Ethics in-service education between 3/12/24, and 3/12/25. During an interview on 4/18/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on Compliance and Ethics for four of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.	F 0946		
F 0947 SS=D		F 0947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0947 SS=D	Continued from page 105 483.95(g)(1)-(4) Required In-Service Training for Nurse Aides §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:	F 0947	Immediate Intervention: All nursing staff were provided with Staff Development training on the electronic platform. How to identify residents who can be affected: All employees can be affected. Prevention of further occurrence: Nurse educator reviewed training platform and discovered that 0947 was not uploaded to the training platform. Staff Development training has since been added to the electronic platform and employees have been given 30 days to complete training. By June 6, 2025, all employees will have 0947 training completed. Corrective action required: nurse educator to review all nurse aide staff training compliance monthly and report to DON delinquent staff. DON will pursue corrective action and discipline for employees who are non-compliant.	Completion Date: 06/09/2025 Status: APPROVED Date: 05/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
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NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502	STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220
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F 0947 SS=D	Continued from page 106	F 0947	QA Program: Nurse educator will report on staff compliance of staff education monthly at QAPI.	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0947 SS=D	Continued from page 107 Based on review of facility policy, staff education records, and staff interviews, it was determined that the facility failed to conduct at least 12 hours of in-service education, within 12 months of their hire date anniversary, for nurse aides as required for two of five nurse aides (Employees Employee E11 and E15). Findings include: Review of the facility policy, "In-Service Training, All Staff" most recently reviewed 3/14/25, indicated all personnel will receive education and training related to resident care. Review of Nurse Aide (NA) Employees Employee E11 and E15 's education records, with hire date greater than 12 months, revealed the following: NA Employee E11 had a hire date of 3/26/23, with approximately four of in-service education between 3/26/24, and 3/26/25.	F 0947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
STATE LICENSE NUMBER: 381502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0947 SS=D	Continued from page 108 NA Employee E15 had a hire date of 4/14/14, with approximately four hours of in-service education between 4/14/24, and 4/14/25. During an interview on 4/18/25, at approximately 1:00 p.m. confirmed that the facility failed to provide the required 12 hours annual in-service education within 12 months of their hire date anniversary for two of five nurse aides. 28 Pa. Code: 201.14(a) Responsibility of Licensee. 28 Pa. Code: 201.20(c) Staff Development.	F 0947		
F 0949 SS=E		F 0949		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
STATE LICENSE NUMBER: 381502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0949 SS=E	Continued from page 109 483.95(i) Behavioral Health Training §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.71. This REQUIREMENT is not met as evidenced by:	F 0949	Immediate Intervention: All nursing staff were provided with Behavior Health training on the electronic platform. How to identify residents who can be affected: All employees can be affected. Prevention of further occurrence: Nurse educator reviewed the training platform and discovered that 0949 was not uploaded to the training platform. Behavior Health Training has since been uploaded, and employees have been given 30 days to complete training. By June 6, 2025, all employees will have 0949 training completed. Corrective action required: nurse educator to review all staff training compliance monthly and report to DON delinquent staff. DON will pursue corrective action and discipline for employees who are non-compliant. QA Program: Nurse educator will	Completion Date: 06/09/2025 Status: APPROVED Date: 05/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502			STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
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F 0949 SS=E	Continued from page 110	F 0949	report on staff compliance of staff education monthly at QAPI.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0949 SS=E	Continued from page 111 Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on behavioral health for eight of ten staff members (Employee E11, E12, E13, E15, E16, E17, E18, and E19). Findings include: Review of the facility policy, "In-Service Training, All Staff" most recently reviewed 3/14/25, indicated all personnel will receive education and training related to resident care. Required training topics include the following: a. Effective communication with residents and family (direct care staff); b. Resident rights and responsibilities; c. Preventing abuse, neglect, exploitation, and misappropriation of resident property including; d. Elements and goals of the facility QAPI program; e. The infection prevention and control program standards, policies and procedures;	F 0949		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
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F 0949 SS=E	Continued from page 112 f. Behavioral health; and g. The compliance and ethics program standards, policies and procedures. (Compliance and ethics training is conducted annually when this organization is operating five or more facilities.) Review of facility provided documents and training records revealed the following staff members did not have documented training on behavioral health: Nurse Aide Employee E11 had a hire date of 3/26/23, failed to have behavioral health in-service education between 3/26/24, and 3/26/25. Nurse Aide Employee E12 had a hire date of 3/8/22, failed to have behavioral health in-service education between 3/8/24, and 3/8/25. Nurse Aide Employee E13 had a hire date of 3/14/05, failed to have behavioral health in-service education between 3/14/24, and 3/14/25. Nurse Aide Employee E15 had a hire date of	F 0949		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
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F 0949 SS=E	Continued from page 113 4/14/14, failed to have behavioral health in-service education between 4/14/24, and 4/14/25. Registered Nurse Employee E16 had a hire date of 4/15/22, failed to have behavioral health in-service education between 4/15/24, and 4/15/25. Medical Records Employee E17 had a hire date of 4/6/10, failed to have behavioral health in-service education between 4/6/24, and 4/6/25. Therapy Employee E18 had a hire date of 2/9/09, failed to have behavioral health in-service education between 2/9/24, and 2/9/25. Registered Nurse Employee E19 had a hire date of 3/12/07, failed to have behavioral health in-service education between 3/12/24, and 3/12/25. During an interview on 4/18/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on behavioral health for eight of ten staff members.	F 0949		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502			STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
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F 0949 SS=E	Continued from page 114 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.	F 0949			

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
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P 1550		P 1550		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
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P 1550	Continued from page 1 Staff development. (1) Accident prevention. This REGULATION is not met as evidenced by:	P 1550	Immediate Intervention: All nursing staff were provided with Accident Prevention training on the electronic platform. How to identify residents who can be affected: All employees can be affected. Prevention of further occurrence: Nurse educator reviewed training platform and discovered that 1550 was not uploaded to the training platform. Accident Prevention has since been uploaded, and employees have been given 30 days to complete training. By June 6, 2025, all employees will have 1550 training completed. Corrective action required: nurse educator to review all staff training compliance monthly and report to DON delinquent staff. DON will pursue corrective action and discipline for employees who are non-compliant. QA Program: Nurse educator will	Completion Date: 06/09/2025 Status: APPROVED Date: 05/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
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STATE LICENSE NUMBER: 381502				
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P 1550	Continued from page 2	P 1550	<p>report on staff compliance of staff education monthly at QAPI.</p> <p>Corrective action required: nurse educator to review all staff training compliance monthly and report to DON delinquent staff. DON will pursue corrective action and discipline for employees who are non-compliant.</p> <p>QA Program: Nurse educator will report on staff compliance of staff education monthly at QAPI.</p> <p>Corrective action required: nurse educator to review all staff training compliance monthly and report to DON delinquent staff. DON will pursue corrective action and discipline for employees who are non-compliant.</p> <p>QA Program: Nurse educator will report on staff compliance of staff education monthly at QAPI.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 1550	Continued from page 3 Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on accident prevention for three of five nurse aides (Employee E11, E13, E15). Findings include: Review of the facility policy, "In-Service Training, All Staff" most recently reviewed 3/14/25, indicated all personnel will receive education and training related to resident care. Review of facility provided documents and training records revealed the following staff members did not have documented training on accident prevention: Nurse Aide Employee E11 had a hire date of 3/26/23, failed to have accident prevention in-service education between 3/26/24, and 3/26/25. Nurse Aide Employee E13 had a hire date of 3/8/22, failed to have accident prevention in-service	P 1550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
STATE LICENSE NUMBER: 381502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 1550	Continued from page 4 education between 3/8/24, and 3/8/25. Nurse Aide Employee E15 had a hire date of 4/14/14, failed to have accident prevention in-service education between 4/14/24, and 4/14/25. During an interview on 4/18/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on accident prevention for three of five nurse aides.	P 1550		
P 1560		P 1560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
STATE LICENSE NUMBER: 381502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 1560	Continued from page 5 Staff development. (2) Restorative nursing techniques. This REGULATION is not met as evidenced by:	P 1560	Immediate Intervention: All nursing staff were provided with Restorative Nursing Techniques on the electronic platform. How to identify residents who can be affected: All employees can be affected. Prevention of further occurrence: Nurse educator reviewed the training platform and discovered that 1560 was not uploaded to the training platform. Restorative Nursing Techniques has since been uploaded, and employees have been given 30 days to complete training. By June 6, 2025, all employees will have 1560 training courses completed. Corrective action required: nurse educator to review all staff training compliance monthly and report to DON delinquent staff. DON will pursue corrective action and discipline for employees who are non-compliant.	Completion Date: 06/09/2025 Status: APPROVED Date: 05/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502			STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
P 1560	Continued from page 6	P 1560	QA Program: Nurse educator will report on staff compliance of staff education monthly at QAPI.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 1560	<p>Continued from page 7</p> <p>Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on restorative nursing techniques for two of five nurse aides (Employee E11 and E15).</p> <p>Findings include:</p> <p>Review of the facility policy, "In-Service Training, All Staff" most recently reviewed 3/14/25, indicated all personnel will receive education and training related to resident care.</p> <p>Review of facility provided documents and training records revealed the following staff members did not have documented training on restorative nursing techniques:</p> <p>Nurse Aide Employee E11 had a hire date of 3/26/23, failed to have restorative nursing techniques in-service education between 3/26/24, and 3/26/25.</p>	P 1560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502			STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
P 1560	Continued from page 8 Nurse Aide Employee E15 had a hire date of 4/14/14, failed to have restorative nursing techniques in-service education between 4/14/24, and 4/14/25. During an interview on 4/18/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on restorative nursing techniques for two of five nurse aides.	P 1560			
P 1570		P 1570			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
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P 1570	Continued from page 9 Staff development. (3) Emergency preparedness in accordance with 42 CFR 483.73(d) (relating to emergency preparedness). This REGULATION is not met as evidenced by:	P 1570	Immediate Intervention: All nursing staff were provided with Emergency Preparedness on the electronic platform. How to identify residents who can be affected: All employees can be affected. Prevention of further occurrence: Nurse educator reviewed training platform and discovered that 1570 was not uploaded to the training platform. Emergency Preparedness has since been uploaded, and employees have been given 30 days to complete training. By June 6, 2025, all employees will have 1570 training courses completed. Corrective action required: nurse educator to review all staff training compliance monthly and report to DON delinquent staff. DON will pursue corrective action and discipline for employees who are non-compliant. QA Program: Nurse educator will	Completion Date: 06/09/2025 Status: APPROVED Date: 05/12/2025

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502			STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
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P 1570	Continued from page 10	P 1570	report on staff compliance of staff education monthly at QAPI.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
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P 1570	<p>Continued from page 11</p> <p>Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on emergency preparedness for two of five nurse aides (Employee E11 and E15).</p> <p>Findings include:</p> <p>Review of the facility policy, "In-Service Training, All Staff" most recently reviewed 3/14/25, indicated all personnel will receive education and training related to resident care.</p> <p>Review of facility provided documents and training records revealed the following staff members did not have documented training on emergency preparedness:</p> <p>Nurse Aide Employee E11 had a hire date of 3/26/23, failed to have emergency preparedness in-service education between 3/26/24, and 3/26/25.</p> <p>Nurse Aide Employee E15 had a hire date of</p>	P 1570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
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P 1570	Continued from page 12 4/14/14, failed to have emergency preparedness in-service education between 4/14/24, and 4/14/25. During an interview on 4/18/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on emergency preparedness for two of five nurse aides.	P 1570		
P 1580		P 1580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
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P 1580	Continued from page 13 Staff development. (4) Fire prevention and safety in accordance with 42 CFR 483.90 (relating to physical environment). This REGULATION is not met as evidenced by:	P 1580	Immediate Intervention: All nursing staff were provided with Fire Prevention and Safety on the electronic platform. How to identify residents who can be affected: All employees can be affected. Prevention of further occurrence: Nurse educator reviewed training platform and discovered that 1580 was not uploaded to the training platform. Fire Prevention and Safety has since been uploaded, and employees have been given 30 days to complete training. By June 6, 2025, all employees will have 1580 training courses completed. Corrective action required: nurse educator to review all staff training compliance monthly and report to DON delinquent staff. DON will pursue corrective action and discipline for employees who are non-compliant. QA Program: Nurse educator will	Completion Date: 06/09/2025 Status: APPROVED Date: 05/16/2025

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
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P 1580	Continued from page 14	P 1580	report on staff compliance of staff education monthly at QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
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P 1580	<p>Continued from page 15</p> <p>Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on fire safety for three of five nurse aides (Employee E11, E13, and E15).</p> <p>Findings include:</p> <p>Review of the facility policy, "In-Service Training, All Staff" most recently reviewed 3/14/25, indicated all personnel will receive education and training related to resident care.</p> <p>Review of facility provided documents and training records revealed the following staff members did not have documented training on fire safety:</p> <p>Nurse Aide Employee E11 had a hire date of 3/26/23, failed to have fire safety in-service education between 3/26/24, and 3/26/25.</p> <p>Nurse Aide Employee E13 had a hire date of 3/14/05, failed to have fire safety in-service</p>	P 1580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
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P 1580	Continued from page 16 education between 3/14/24, and 3/14/25. Nurse Aide Employee E15 had a hire date of 4/14/14, failed to have fire safety in-service education between 4/14/24, and 4/14/25. During an interview on 4/18/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on fire safety for three of five nurse aides.	P 1580		
P 5520		P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
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P 5520	Continued from page 17 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	The facility will implement a corrective staffing plan led by the Staffing Coordinator and overseen by the Director of Nursing and Administrator. The Staffing Coordinator will use a facility software to verify projected ratios tracking tool to calculate required hours per shift daily based on resident census and will ensure adequate staffing coverage is planned in advance. A float pool and an on-call list of PRN staff will be developed to cover unexpected absences or shortfalls. Additionally, the facility will continue the recruitment effort to increase the availability of certified nurse aides. Starting June 9, daily staffing compliance reports will be submitted to the Administrator and reviewed in QAPI meeting. In-service training will be conducted for administrative staff on regulatory staffing requirements and the importance of maintaining minimum staffing ratios. To ensure sustained compliance, the Administrator or designee will conduct weekly audits of the	Completion Date: 06/09/2025 Status: APPROVED Date: 05/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
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P 5520	Continued from page 18	P 5520	<p>staffing schedules to:</p> <p>Compare projected vs. actual staffing per shift</p> <p>Verify adherence to required ratios</p> <p>Ensure appropriate documentation and use of PRN/on-call staff when needed</p> <p>Audit results will be discussed in weekly QAPI meetings beginning June 9, 2025.</p> <p>After the initial 30-day audit period, the facility will continue with monthly audits through the remainder of the calendar year to ensure ongoing compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
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P 5520	Continued from page 19 Based on review of nursing time schedules and staff interviews, it was determined that the facility administrative staff failed to provide a minimum of one nurse aide per 10 residents during the day shifts, one nurse aide per 11 residents on evening shift, and one nurse aide per 15 residents on night shift, on 12 of 21 days (3/23/25, 3/24/25, 4/1/25, 4/2/25, 4/3/25, 4/4/25, 4/5/25, 4/6/25, 4/8/25, 4/9/25, 4/10/25, and 4/11/25). Findings include: Review of the nursing schedules and census information for 3/23/25, through 4/12/25, revealed that the facility failed to meet the following: 3/23/25: Evening shift required 99.55 hours of nurse aide care, facility provided 97.50. 3/24/25: Night shift required 73.00 hours of nurse aide care, facility provided 67.50. 4/01/25: Evening shift required 94.09 hours of nurse aide care, facility provided 87.00; night shift required 69.00 hours of nurse aide care, facility	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE STATE LICENSE NUMBER: 381502		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
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P 5520	Continued from page 20 provided 67.00. 4/02/25: Evening shift required 96.14 hours of nurse aide care, facility provided 96.00; night shift required 70.50 hours of nurse aide care, facility provided 64.00. 4/03/25: Evening shift required 96.14 hours of nurse aide care, facility provided 89.00; night shift required 70.50 hours of nurse aide care, facility provided 54.00. 4/04/25: Day shift required 105.75 hours of nurse aide care, facility provided 90.00; evening shift required 96.14 hours of nurse aide care, facility provided 90.00; night shift required 70.50 hours of nurse aide care, facility provided 65.00. 4/05/25: Evening shift required 96.82 hours of nurse aide care, facility provided 90.00; night shift required 71.00 hours of nurse aide care, facility provided 60.00. 4/06/25: Day shift required 96.82 hours of nurse aide care, facility provided 90.00. 4/08/25: Day shift required 104.25 hours of nurse aide care, facility provided 87.00; evening shift required 94.77 hours of nurse aide care, facility	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
STATE LICENSE NUMBER: 381502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5520	Continued from page 21 provided 91.00 4/09/25: Evening shift required 94.77 hours of nurse aide care, facility provided 90.00. 4/10/25: Day shift required 103.50 hours of nurse aide care, facility provided 100.00; evening shift required 94.09 hours of nurse aide care, facility provided 90.50; night shift required 69.00 hours of nurse aide care, facility provided 67.50. 4/11/25: Evening shift required 93.41 hours of nurse aide care, facility provided 92.00; night shift required 68.50 hours of nurse aide care, facility provided 60.00. During a follow-up electronic communication on 4/21/25, at 8:47 p.m. the Nursing Home Administrator confirmed that the facility administrative staff failed to provide a minimum of one nurse aide per 10 residents during the day shifts, one nurse aide per 11 residents on evening shift, and one nurse aide per 15 residents on night shift, on 12 of 21 days.	P 5520		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: CARNEGIE PARK POST ACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1848 GREENTREE ROAD PITTSBURGH, PA 15220		
STATE LICENSE NUMBER: 381502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5640	Continued from page 22 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	The Staffing Coordinator will implement a daily tracking process in the facility software program to monitor projected and actual nursing hours PPD. This tool will calculate staffing requirements based on daily census and will be reviewed by the Administrator each morning to ensure adequate coverage. If staffing levels are projected to fall below the minimum threshold, the Coordinator will call-in procedure to utilize PRN staff, float pool personnel, or approved agency staff. The facility will also continue recruiting methods to bring more staff in. Administrative staff will be re-educated on minimum nursing hour requirements and their role in meeting them. Daily staffing logs will be audited for 30 days beginning June 9, and results will be reviewed weekly in QAPI meetings. To ensure sustained compliance, the DON or designee will conduct weekly audits of the prior week's staffing logs for accuracy and completeness. These audits will confirm that the 3.2 PPD minimum is met, verify proper	Completion Date: 06/09/2025 Status: APPROVED Date: 05/16/2025

Pennsylvania Department of Health

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P 5640	Continued from page 23	P 5640	<p>documentation of census and hours, and confirm any corrective actions taken if shortfalls occur. Results of these audits will be reviewed weekly during QAPI meetings.</p> <p>Following the initial 30-day audit period, the facility will transition to monthly staffing audits for the remainder of the calendar year to monitor long-term compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
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P 5640	Continued from page 24 Based on review of nursing time schedules and staff interviews it was determined that the facility administrative staff failed to provide the minimum number of general nursing hours to each resident in a 24 hour period on six of 21 days (4/3/25, 4/4/25, 4/5/25, 4/8/25, 4/10/25, and 4/11/25). Findings include: Review of the nursing schedules and census information for 3/23/25, through 4/12/25, revealed that the facility failed to maintain 3.20 hours of general nursing care to each resident in a 24-hour period on the following dates: -4/03/25, Census 141. PPD 3.16. -4/04/25, Census 141. PPD 3.16. -4/05/25, Census 142. PPD 3.14. -4/08/25, Census 139. PPD 3.19. -4/10/25, Census 138. PPD 2.97. -4/11/25, Census 137. PPD 3.13. During a follow-up electronic communication on	P 5640		

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395743	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 04/18/2025
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P 5640	Continued from page 25 4/21/25, at 8:47 p.m. the Nursing Home Administrator confirmed that the facility failed to provide the minimum number of general nursing hours to each resident in a 24-hour period on six of 21 days.	P 5640			

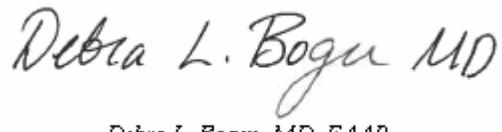


Certified End Page

CARNEGIE PARK POST ACUTE
STATE LICENSE NUMBER: 381502
SURVEY EXIT DATE: 04/18/2025

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, FAAP
Secretary of Health



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

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