STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395883	A. BLDG: 00 B. WING:	03/13/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BURGH CARE CENTER STATE LICENSE NUMBER: **016002**	**909 WEST STREET** **PITTSBURGH, PA 15221**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Findings of an abbreviated survey in response to an incident, completed on March 13, 2025, it was determined Burgh Care Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0610 SS=D		F 0610		

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 0610 SS=D	Continued from page 1 483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0610	Burgh Care Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Burgh Care Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, urgh Care Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F- 610 Investigate/Prevent/Correct Alleged Violation 1. Elopement Procedure was implemented by the Director of Nursing to search for the resident on	Completion Date: **04/15/2025** Status: **APPROVED** Date: **04/01/2025**

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F 0610 SS=D	Continued from page 2	F 0610	2/25/25. Event Report submitted to DOH by the Administrator on 2-26-25. Physician, Police, and Area Agency on Aging were notified by the Administrator on 2/25/25. Statements were gathered from the staff and residents by the Administrator on 2/25/25 and 2/26/25. The Elopement Book was updated by the Director of Nurses by 2/25/25. A Root Cause Analysis was completed by the Administrator on 2/26/25. Elopement Drills were conducted on each shift by the Human Resources Director by 2/28/25. The staff was educated on the Elopement Policy and Procedure by the Human Resources Director started on 2/25/25. The elopement assessment was rewritten by the Regional Clinical Director and Director of Nursing on March 13, 2025 The Resident LOA Policy was updated on March 13, 2025, by the Administrator to include a system	

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F 0610 SS=D	Continued from page 3	F 0610	requiring the orders are reviewed before allowing the residents to leave the facility. An Ad Hoc QAPI Meeting was held by the Administrator on 2/25/25. 2. A revised elopement Assessment was completed on each resident by the Director of Nursing and Assistant Director of Nursing on 3/13/25. 3. The Resident LOA Policy was updated on March 13, 2025, to include a system requiring that the orders are reviewed before allowing the residents to leave the facility. An audit will be completed on each new admission by the Administrator or designee to assess each resident against the four risk factors identified in the Root Cause Analysis. These audits will be completed weekly for 3 weeks then monthly for 2 months. An audit will be completed by the Director of Nurses or designee to ensure that the elopement assessments have been completed for new admissions, readmissions, quarterly, and change of condition.	

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F 0610 SS=D	Continued from page 4	F 0610	These audits will be completed weekly for 3 weeks then monthly for 2 months. Audits will be completed by the Administrator or designee to ensure the LOA policy change is being properly implemented. This will be completed weekly for 3 weeks then monthly for 2 months. 4. A summary of the audits will be reviewed in the monthly QAPI meeting for 2 months.	

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F 0610 SS=D	Continued from page 5 Based on review of facility policy, clinical record review and staff interview, it was determined that the facility failed to fully investigate an incident to eliminate possible abuse or neglect for one of three residents (Resident R1). Findings include: Review of the facility "Accidents and Incidents-Investigating and Reporting" policy reviewed 9/1/24, indicated all incidents involving residents shall be investigated and reported to the administrator. It was indicated witnesses and their accounts of the incident must be included in the Report of Incident/Accident Form. Review of Resident R1's admission record indicated he was admitted on 2/21/25, with diagnoses of opioid abuse, alcohol abuse, psychoactive substance abuse, and cerebral infarction (commonly referred to as a stroke, occurs when the blood supply to the brain is interrupted, leading to a lack of oxygen and nutrients to brain	F 0610		

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F 0610 SS=D	Continued from page 6 cells.) Review of information submitted to the Department of Health on 2/26/25, indicated on 2/25/25, Resident R1 had an unauthorized LOA from the facility around 2:15 p.m. It was indicated the supervisor saw the resident walking away from the property and heading towards the bus stop, and immediately notified the Director of Nursing (DON). It was indicated he was dressed in street clothes with a winter coat. Staff members searched the area around the facility and called the resident's listed phone number. It was indicated the number listed was a place he had been staying prior to hospitalization and has since been evicted. A review of a progress note dated 2/27/25, at 11:04 a.m. entered by the Director of Nursing indicated a case manager called to see if the facility had any whereabouts on Resident R1. It was indicated the DON told the case worker that the facility was not aware of where he had gone. The DON asked the case manager to contact the facility	F 0610		

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F 0610 SS=D	Continued from page 7 if she has any information on where the resident is and his condition. Review of Medical Records, Employee E3's witness statement dated 2/26/25, indicated on 2/25/25, she was taking the residents out for their 2 p.m. smoke break. When she started to light residents cigarettes as they came out of the door, she told them to keep the line moving towards the smoking area. On the way out she indicated there were people yelling and talking to each other. Resident R5 approached Medical records, Employee E3 and stated "that man left out and walked off the property." It was indicated Medical Records, Employee E3 asked what man, and he proceeded to say the man with the black coat with the fur around the hood. It was indicated while heading outside Medical Record, Employee E3 seen Resident R1 walking down the driveway with Dietary Aide, Employee E4. She stated she never seen him before, and was unaware he was a resident. The Medical Records, Employee E3 ran inside and told the Director of Nursing who was standing in the lobby and proceeded to do the	F 0610		

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F 0610 SS=D	Continued from page 8 elopement protocol. During an interview on 3/12/25, at 9:36 a.m. Registered Nurse (RN) Supervisor, Employee E5 stated she work 7 a.m. to 3 p.m. the day Resident R1 eloped. She stated she didn't know him well. It was indicated just before he eloped he was sitting in the common area at the table. RN Supervisor, Employee E5 stated "It was almost time to smoke, the smokers went out, I stayed in my office, I guess he saw that as his opportunity." It was indicated sometime shortly after that staff began to search for the resident. RN Supervisor, stated the elopement risk screening tool just uses nursing judgement to determine if a resident is an elopement risk. A review of the facility's investigation for Resident R1's elopement on 3/12/25, at 9:15 a.m. revealed the facility failed to obtain Resident R5's, Dietary Aide, Employee E4, and RN Supervisor, Employee E5's witness statements. During an interview on 3/12/25, at 9:22 a.m., the	F 0610		

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F 0610 SS=D	Continued from page 9 DON confirmed the facility failed fully investigate Resident R1's elopement to rule out neglect. 28 Pa Code: 201.18 (e)(1)(2) Management. 28 Pa Code: 201.29 (a)(c)(d) Resident Rights. 28 Pa Code: 211.12(c)(d)(1)(3)(5) Nursing services.	F 0610		
F 0660 SS=D		F 0660		

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F 0660 SS=D	Continued from page 10 483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences.	F 0660	F-660 Discharge Planning 1. A discharge order was obtained for R1. 2. Resident discharges will be reviewed at the next Clinical Meeting to ensure compliance with the discharge process. 3. The IDT Team will be educated on the discharge policy and procedure to include all items needed for discharge. The Director of Nursing or designee will audit all discharges weekly for 2 weeks and then monthly for 2 months to ensure discharges are completed per policy. 4. A summary of the results of the audits will be reviewed by the Director of Nursing or designee in the Monthly QAPI meeting for 2 months	Completion Date: **04/15/2025** Status: **APPROVED** Date: **03/31/2025**

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F 0660 SS=D	Continued from page 11 (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant	F 0660		

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F 0660 SS=D	Continued from page 12 resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by:	F 0660		

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F 0660 SS=D	Continued from page 13 Based on review of facility policy, clinical record review, resident and staff interviews it was determined that the facility failed to provide discharge planning for resident needs prior to discharge for one of three residents (Resident R1). Findings include: Review of the facility policy "Discharging the Resident" last reviewed 9/18/24, indicated the resident should be consulted about the discharge process. The resident's condition must be assessed and documented at discharge including skin assessment, if medical condition allows. All ambulatory residents being discharged must be transported to the pickup area by wheelchair. All the necessary equipment and supplies should be assembled to discharge the resident. Review of Resident R1's admission record indicated he was admitted on 2/21/25, with diagnoses of opioid abuse, alcohol abuse, and other psychoactive substance abuse, and cerebral infarction (commonly	F 0660		

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F 0660 SS=D	Continued from page 14 referred to as a stroke, occurs when the blood supply to the brain is interrupted, leading to a lack of oxygen and nutrients to brain cells.) Review of Resident R1's Brief Interview for Mental Status (BIMS) assessment dated 2/24/25, completed by Social Service Director Employee E2 indicated the resident was cognitively intact. Review of information submitted to the Department of Health on 2/26/25, indicated on 2/25/25, Resident R1 had an unauthorized leave of absence from the facility around 2:15 p.m. Review of Resident R1's MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) signed on 2/28/25, at 11:09 a.m. by Registered Nurse Assessment Coordinator, Employee E13 indicated the resident was discharged on 2/25/25, with return not anticipated. Review of Resident R1's physician orders dated	F 0660		

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F 0660 SS=D	Continued from page 15 2/25/25, failed to include an order to discharge the resident. A review of a progress note dated 2/27/25, at 11:04 a.m. entered by the Director of Nursing indicated a case manager called to see if the facility had any whereabouts on Resident R1. It was indicated the DON told the case worker that the facility was not aware of where he had gone. The DON asked the case manager to contact the facility if she has any information on where the resident is and his condition. Review of Resident R1's clinical record failed to provide further information on Resident R1's whereabouts after 2/7/25. Review of Resident R1's care plan initiated 2/28/25, three days after the resident eloped indicated a potential for discharge to the community. It was indicated to discuss the resident's abilities and needs with the appropriate staff to determine what services the resident will need in the community and to	F 0660		

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F 0660 SS=D	Continued from page 16 establish a tentative discharge date. During an interview on 3/13/25, at 10:31 a.m. RNAC, Employee E13 indicated a discharge MDS for an elopement should be coded as an unplanned discharged, with a return anticipated. If the facility finds out if a resident is not returning, then it can be changed to discharged, return not anticipated. RNAC, Employee E13 stated the reason she completed the discharge MDS assessment for Resident R1 after he eloped on 2/25/25, was because she talked to regional and the police anticipated he would not return. She indicated Resident R1 verbalized he did not have a home. During an interview on 6/20/24, at 3:03 a.m. the Nursing Home Administrator confirmed the facility failed to complete a timely and safe discharge for Resident R1. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services.	F 0660		

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F 0660 SS=D	Continued from page 17	F 0660		
F 0689 SS=J		F 0689		

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F 0689 SS=J	Continued from page 18 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	F-689 Free of Accidents Hazards/ Supervision/ Devices 1. Resident R1 is no longer a resident at the facility but was located post elopement by the housing director of the YMCA where the resident had lived prior to hospitalization. Resident is safe according to his friends in the northside area where he has been a lifelong resident. This was verified by the Administrator on 12 March 2025. 2. All residents will be assessed for elopement risk by the Director of Nursing or designee by the end of the day on 13 March 2025. All care plans for residents identified with elopement risks will be reviewed and updated with interventions to prevent elopement by the end of the day on 13 March 2025 by the Director of Nursing or designee. Residents admitted within the last 30 days and who are currently in -house will be added to the Elopement Binder by the Administrator or designee by 13 March 2025.	Completion Date: **04/15/2025** Status: **APPROVED** Date: **03/31/2025**

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F 0689 SS=J	Continued from page 19	F 0689	3. The elopement assessment tool will be updated by the Director of Nursing or designee by 13 March 2025. Education will be completed by all staff on Elopement Risks, Assessments, Care Plans, and Supervision of Residents by the Director of Nursing or designee by 13 March 2025. Policies and/or procedures will be updated to identify residents who are at risk for eloping by the Administrator or designee by 13 March 2025. Elopement Books with identified resident photos will be placed on all nurses stations in addition to the current one at the receptionist's desk by the Administrator or designee by 13 March 2025. A new process will be implemented by the Administrator or designee to ensure that Residents sign out of the facility when going on an LOA. This process will have the Registered Nurse (RN) Supervisor or designated nurse (RN or LPN) complete an LOA Approval Form which is to be given	

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F 0689 SS=J	Continued from page 20	F 0689	to the Receptionist before the receptionist can allow the resident to exit the facility by 13 March 2025. The Directed Inservice for F-689, entitled Accident Prevention and Supervision will be conducted by Affinity Health Services on April 4, 2025. 4. Audits will be implemented by the Nursing Home Administrator o designee for LOA Sign Out compliance weekly for 3 weeks and then monthly for 2 months. Audits will be implemented weekly for 3 weeks and then monthly for 2 months to monitor that the elopement assessments have been completed at admission, quarterly, and with changes in conditions. An Ad Hoc Quality Assurance and Process Improvement Meeting will be held by the Administrator or designee by the 13 March 2025. This plan of correction will be monitored at the Quality Assurance and Process Improvement meeting until such time consistent substantial compliance has been met.	

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F 0689 SS=J	Continued from page 21 Based on review of facility policy and documents, clinical records, and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision and failed to identify a resident who was an elopement risk which resulted in an elopement for one of five residents (Resident R1). This failure created an immediate jeopardy situation. Findings include: Review of the facility "Wandering and Elopements" policy last reviewed 9/18/24, indicated the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Elopement screenings will be completed on residents upon admission, change in condition, and as needed. When a resident is identified to be "at risk for elopement," they will be care planned along with interventions identified to reduce the resident's risk for elopement. Residents being identified as being at risk will have the Resident	F 0689		

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F 0689 SS=J	Continued from page 22 Identification Form completed with a current picture. The completed form will be placed in the Elopement Risk Binder located at each nursing station and the front exit. If an employee observes a resident leaving the premises, he/she should attempt to prevent the resident from leaving, get help from other staff members in the immediate vicinity, and if needed instruct another staff member to inform the charge nurse or Director of Nursing (DON) that a resident is attempting to leave or has left the premises. When the resident returns to the facility the DON or charge nurse must examine the resident, contact the attending physician and report findings and conditions of the resident. Review of Resident R1's admission record indicated he was admitted on 2/21/25, with diagnoses of opioid abuse, alcohol abuse, psychoactive substance abuse, and cerebral infarction (commonly referred to as a stroke, occurs when the blood supply to the brain is interrupted, leading to a lack of oxygen and nutrients to brain cells.)	F 0689		

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F 0689 SS=J	Continued from page 23 Review of Resident R1's Elopement Risk Evaluation dated 2/21/25, indicated the resident was not an elopement risk. Review of Resident R1's care plan dated 2/24/25, indicated Resident R1 had a behavior problem with entering into other resident's rooms and defecating on the floors. Review of Resident R1's Brief Interview for Mental Status (BIMS) assessment dated 2/24/25, completed by Social Service Director Employee E2 indicated the resident was cognitively intact. Review of Resident R1's Elopement Risk Evaluation dated 2/24/25, asked nine questions and it was indicated "an answer of "Yes" for ANY of the above indicates Risk of Elopement, proceed with identification of resident as an elopement risk including but not limited to wander guard placement and facility notification. Proceed to the Care Plan and Initiate." The resident answered yes for two of nine questions. It was indicated the resident wanders	F 0689		

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F 0689 SS=J	Continued from page 24 and was recently admitted and was not accepting the situation. The facility failed to initiate a care plan for the resident's elopement risk. Review of a progress note dated 2/25/25, at 3:28 p.m. entered by Licensed Practical Nurse (LPN), Employee E1 stated Resident R1 was seen first while passing medications. Resident R1 was sitting in the common area and kept insisting that family is unaware of where Resident is at and needs to go tell them. LPN, Employee E1 looked in the resident's clinical record and there was not contact information for any family. The resident was last seen around 11:00 a.m. in the common area. Review of Resident R1's clinical record on 2/25/25, failed to indicate Resident R1 was reevaluated for a risk of elopement after displaying exit-seeking behaviors. Review of information submitted to the Department of Health on 2/26/25, indicated on 2/25/25, Resident R1 had an unauthorized LOA from the	F 0689		

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F 0689 SS=J	Continued from page 25 facility around 2:15 p.m. It was indicated the supervisor saw the resident walking away from the property and heading towards the bus stop, and immediately notified the DON. Resident R1 was dressed in street clothes with a winter coat. The resident was assessed for elopement and was determined not to be a risk. Staff members searched the area around the facility and called the resident's listed phone number. The number listed was a place he had been staying prior to hospitalization and has since been evicted. The police, physician, and appropriate agencies were notified. Review of Social Service Director, Employee E2's witness statement dated 2/25/25, indicated on 2/24/25, Resident R1 stated, "he/she needed to get out to take care of a few things." On 2/25/25, around 2:50 p.m. was notified Resident R1 walked off the property and staff was looking for resident. Review of Nurse Aide, Employee E12's undated witness statement indicated Resident R1 asked to use NA, Employee E12's phone and called	F 0689		

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F 0689 SS=J	Continued from page 26 someone multiple times. It was indicated apparently it was a family member. Review of Medical Records, Employee E3's witness statement dated 2/26/25, indicated on 2/25/25, residents were being taking out for their 2 p.m. smoke break. Medical Records, Employee E3 started to light resident's cigarettes as they came out of the door and told them to keep the line moving towards the smoking area. On the way-out Medical Records, Employee E3 indicated there were people yelling and talking to each other. Resident R5 approached medical records, Employee E3 and stated, "that man left out and walked off the property." Medical Records, Employee E3 asked what man, and he proceeded to say the man with the black coat with the fur around the hood. While heading outside Medical Record, Employee E3 seen Resident R1 walking down the driveway with Dietary Aide, Employee E4. Medical Records, Employee E3 stated she never seen him before and was unaware he was a resident. Medical Records, Employee E3 ran inside and told the Director of	F 0689		

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F 0689 SS=J	Continued from page 27 Nursing who was standing in the lobby and proceeded to do the elopement protocol. A review of a progress note dated 2/27/25, at 11:04 a.m. entered by the Director of Nursing indicated a case manager called to see if the facility had any whereabouts on Resident R1. It was indicated the DON told the case worker that the facility was not aware of where he had gone. The DON asked the case manager to contact the facility if she has any information on where the resident is and his condition. A review of the facility's investigation for Resident R1's elopement on 3/12/25, at 9:15 a.m. indicated the resident was last seen leaving the property at the end of the driveway. Resident R1 exited the facility at approximately 2:30 p.m. with a dietary aide. The resident was wearing black pants, a black puffy coat with the hood up, dark shoes, and dark rimmed glasses. The weather was 50 degrees Fahrenheit and cloudy. The facility does not have an alarm system for the doors. It was indicated the resident	F 0689		

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F 0689 SS=J	Continued from page 28 was assessed for an elopement risk but was not a risk. The facility failed to identify Resident R1 as an elopement risk. During an interview on 3/12/25, at 9:36 a.m. RN Supervisor, Employee E5 stated she worked 7 a.m. to 3 p.m. the day Resident R1 eloped, and indicated she didn't know Resident R1 well. RN, Supervisor, Employee E5 stated Resident R1 was seen sitting in the common area just before he eloped. RN Supervisor, Employee E5 stated "It was almost time to smoke, the smokers went out, I stayed in my office, I guess he saw that as his opportunity." Sometime shortly after that staff began to search for the resident. RN Supervisor stated the elopement risk screening tool only uses nursing judgement to determine if a resident is an elopement risk. During an interview on 3/12/25, at 9:53 a.m. LPN, Employee E1 stated she worked 7 a.m. to 3 p.m. on 2/25/25. LPN, Employee E1 stated Resident R1 wasn't always nice and kept requesting to see his family. LPN, Employee E1 didn't see any family's	F 0689		

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F 0689 SS=J	Continued from page 29 contact information listed on Resident R1's clinical record. LPN, Employee E1 stated Resident R1 was homeless. Resident R1 went all day saying no one knows where he is at, and he needs to get out of here. LPN, Employee E1 stated she was unsure when to reevaluate residents for elopement risks. LPN, Employee E1 stated around 2 p.m. she was notified Resident R1 was missing. A search was conducted for Resident R1; however, he was not located. During an interview on 3/12/25, at 10:03 a.m. Social Services Director, Employee E2 stated the day before, Resident R1 eloped, he indicated he needed to make some phone calls and had to make a plan. Social Service Director, Employee E2 asked what Resident R1's plan was, and Resident R1 indicated he didn't have a plan. The next day Resident R1 "took off" and the elopement protocol was initiated sometime between 2 p.m. and 3 p.m. No one heard from him since. During an interview on 3/12/25, at 10:10 a.m.	F 0689		

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F 0689 SS=J	Continued from page 30 Nurse Aide, Employee E6 stated the front doors are always locked and someone must push the button to let anyone out. NA, Employee E6 stated if resident displays exit-seeking behaviors a nurse must be notified. During an interview on 3/12/25, at 10:17 a.m. Medical Records, Employee E3 stated she covers the smoking breaks at 10 a.m. and 2 p.m. During a smoke break on 2/25/25, the doors were open and shut, with people were coming in from outside. Medical Records, Employee E3 was outside, holding the door and told residents to go to the pavilion, and wait for her to light their cigarettes. During that time Dietary Aide, Employee E4 and Resident R1 came out and kept walking. Medical Records, Employee E3 indicated she didn't realize Resident R1 was a resident at the facility. Resident R5 said "that man left", and indicated she thought Resident R5 was talking about Dietary Aide, Employee E4. Medical Records, Employee E3 asked Resident R5 if it was the guy sitting in the lobby. Medical Records, Employee E3 notified	F 0689		

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F 0689 SS=J	Continued from page 31 Receptionist, Employee E7 that Resident R5 told her a resident left and to complete a floor check and head count. Medical Records, Employee E3 stated once notified, Resident R1 was already gone. Medical Records Employee E3 asked Resident R5 "why wouldn't you tell me when you saw him leaving, I would have run down parking lot." Medical Records, Employee E3 stated Resident R1 "didn't even come over to the pavilion." She stated the police were notified but it took a long time to come, and the facility had to call again. Resident R1 never came out to smoke before. On 3/12/25, at 10:36 a.m. Resident R5 was unavailable for an interview and was out to the hospital. During an interview on 3/12/25, at 10:37 a.m. Nurse Aide, Employee E8 stated she was assigned to Resident R1 on 2/25/25. NA, Employee E8 works at the facility once a week, and was unfamiliar with Resident R1, however was aware Resident R1 was independent with care. NA,	F 0689		

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F 0689 SS=J	Continued from page 32 Employee E8 seen Resident R1 throughout the day, and didn't notice any exit seeking behaviors. NA, Employee E8 stated a nurse would have notified if a resident displayed exit-seeking behaviors. The last time NA, Employee E8 seen Resident R1 on 2/25/25, was around 1 p.m. Once notified Resident R1 was missing, NA, Employee E8 got in her car and started looking for Resident R1. During an interview on 3/12/25, at 10:42 a.m. the NHA and DON indicated Resident R1 walked out with Dietary Aide, Employee E4. The DON stated, "it looked like they were together." It was indicated the Dietary Aide, Employee E4 did not have a conversation with Resident R1. Resident R1 had his hood up and walked out the door. Medical Records, Employee E3 was doing the smoking break that day. It was indicated they believe Resident R1 got on a bus, because if Resident R1 was on foot, he would have been found. The NHA and DON stated Resident R1 "should not have been identified as an elopement risk." The DON stated, "all the assessments we did, didn't show he was	F 0689		

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F 0689 SS=J	Continued from page 33 either." The DON and NHA confirmed the facility failed to identify Resident R1 was at risk for elopement and ensure Resident R1 was care planned for his risk and received adequate supervision to prevent elopement. During an interview on 3/12/25, 11:31 a.m. the DON stated since Resident R1 had two elopement risk assessments completed in the first few days. He indicated he was not sure an updated elopement assessment would have been completed on 2/25/25, the day the resident displayed exit-seeking behaviors and eloped. On 3/12/25, at 1:13 p.m. the NHA and DON were notified that Immediate Jeopardy was called due to the elopement of Resident R1 on 2/25/25, and facility staff were provided an Immediate Jeopardy template, and a corrective action plan was requested. During an interview on 3/12/25, at 2:31 p.m. Receptionist, Employee E10 stated she works at the	F 0689		

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F 0689 SS=J	Continued from page 34 front desk Monday through Friday from 7a.m. until 3 p.m. Receptionist, Employee E10 stated the front doors are always locked and a staff member must push a button located behind the desk to open the doors. An elopement book is located at the front desk with residents' photos who are identified as an elopement risk. Staff must identify those who are leaving prior to unlocking the door. Whenever a resident is identified as an elopement risk, the binder is updated. It was indicated Receptionist, Employee E10 trains all staff to study the photos of residents to prevent anyone from eloping. On 3/12/25, at 5:13 p.m. an immediate action plan was received and accepted which included the following interventions: 1. Immediate action(s) taken for the resident(s) found to have been affected include: -Resident R1 is no longer a resident at the facility but was located post elopement by the housing director of the YMCA where the resident had lived	F 0689		

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F 0689 SS=J	Continued from page 35 prior to hospitalizations. Resident is safe according to his friends in the northside area where he has been a lifelong resident. This was verified by the Administrator on 3/12/25. 2. Identification of other residents having the potential to be affected was accomplished by: -All residents will be assessed for elopement risk by the Director of Nursing or designee by the end of the day on 3/13/25. -All care plans for residents identified with elopement risks will be reviewed and updated with interventions to prevent elopement by the end of the day on 3/13/15, by the DON or designee. -Residents admitted within the last 30 days and who are currently in-house will be added to the Elopement Binder by the NHA or designee by 3/13/25. 3. Actions taken/systems put into place to reduce	F 0689		

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F 0689 SS=J	Continued from page 36 the risk of future occurrences include: -The elopement assessment tool will be updated by the Director of Nursing or Designee by 3/13/25. -Education will be completed by all staff on Elopement Risks, Assessments, Care Plans, and Supervision of residents by the DON or designee by 3/13/25. -Policies and/or procedures will be updated to identify residents who are at risk for eloping by the NHA or designee by 3/13/25. -Elopement Books with identified resident photos will be placed on all nurses' stations in addition to the current one at the receptionist's desk by the NHA or designee by 3/13/25. -A new process will be implemented by the NHA or designees to ensure that residents sign out of the facility when going on a leave of absences (LOA). This process will have the RN Supervisor or	F 0689		

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F 0689 SS=J	Continued from page 37 designated nurse (RN or LPN) will complete an LOA approval form which is to be given to the receptionist before the receptionist can allow the resident to exit the facility by 3/13/25. 4. How the corrective actions(s) will be monitored to ensure the practice will not recur: -Audits will be implemented by 3/13/25, for LOA sign out compliance weekly for 4 weeks, then monthly for two months. -An Ad Hoc Quality Assurance and Process Improvement Meeting will be held by the NHA or designee by 3/13/25. -This plan of correction will be monitored at the QAPI meeting until such time is consistent substantial compliance has been met. On 3/13/25, at 12:43 p.m. it was confirmed 78/78 Residents were reassessed for an elopement risk. 13/78 Residents were identified as a risk, and 13/13	F 0689		

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F 0689 SS=J	Continued from page 38 care plans were updated to include interventions to prevent elopement. 13/13 Residents were included in the elopement binder. On 3/13/25, at 12:46 p.m. it was confirmed the elopement tool assessment was updated to include residents who were recently admitted or readmitted in last 30 days. The new tools assesses if in last 90 days does the resident have history of elopement or attempt to leave the facility without informing the staff, has the resident been witnessed packing belongings with intent to leave facility, has the resident been exit seeking, has the resident been in non-resident care area, and/or unsupervised area. Residents who answer yes to questions 2-4 will be identified as an elopement risk. If triggered yes, the tool auto populates a care plan task to be completed. During in-person interviews completed from 3/13/25, at 10:31 a.m. until 3/13/25, at 12:05 p.m. 18/18 staff confirmed they were educated. Staff were educated on how and when to complete an	F 0689		

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F 0689 SS=J	Continued from page 39 elopement assessment, and what to do for residents that are displaying exit seeking behaviors. 91/120 Staff were educated on the elopement risks, assessments, care plans, and supervision of residents on 3/13/25. Staff were sent an alert that was signed and acknowledge for the elopement risk training and all staff must confirm they were educated prior to the start of their next shift. 90/120 Staff members signed the acknowledgement of elopement training. During phone interviews completed on 2/13/25, at 2:10 p.m. at 5 of 5 staff members confirmed they were educated on elopement risks. All staff must confirm they were educated prior to the start of their next shift and sign the education sheet in-person. Staff education was verified with dated sign-in sheets and review of all current staff utilized in the facility having signed and/or educated over the phone as indicated. Policies for elopement was reviewed on 3/12/25, no	F 0689		

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F 0689 SS=J	Continued from page 40 updates were made. Elopement books with 13/13 Identified residents were observed at 2 of 2 nursing stations and the front desk. The residents' photos and names were listed. The facility created LOA approval forms that are located at each nursing station. It is indicated the form must be filled out and given to Receptionist before the receptionist can allow the resident to exit. An audit was completed for residents with a LOA on 3/13/25. No residents went on LOA. The facility will continue to audit weekly. An Ad Hoc QA Meeting was completed on 3/13/25. Verification of the facility's Corrective Action Plan revealed all elements of plan were met. The Immediate Jeopardy was lifted on 3/13/25, at 2:32 p.m.	F 0689		

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F 0689 SS=J	Continued from page 41 During an interview on 3/13/25, at 3:03 p.m., the NHA and Regional Clinical Operations Specialist, Employee E9 confirmed that the facility failed to make certain each resident received adequate supervision and failed to identify and implement interventions for a resident who was an elopement risk which resulted in an elopement for one of five residents (Resident R1), resulting in Immediate Jeopardy. 28 Pa. Code§ 201.14(a) Responsibility of Licensee. 28 Pa. Code § 211.10(d) Resident care policies. 28 Pa. Code § 211.12(d)(5) Nursing Services.	F 0689		
F 0712 SS=D		F 0712		

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F 0712 SS=D	Continued from page 42 483.30(c)(1)-(4) Physician Visits-Frequency/Timeliness/Alt NPP §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by:	F 0712	F-712 Physician Visits – Frequency/ Timeliness/ Alt NP 1. The cited areas cannot be corrected. 2. An audit of new admissions will be conducted by the Administrator or designee for the past 30 days to determine compliance with the regulation. 3. The Medical Director, attending physician, and nurse practitioners will be educated on regulation F-712 by the Director of Nursing or designee. 4. Audits will be completed by the Administrator or designee for the completion of the Comprehensive Visits by the physician within 10 days on all new admissions weekly for 3 weeks and then monthly for 2 months. A summary of the audits will be reviewed in the monthly QAPI for 2 months by the Administrator or designee.	Completion Date: **04/15/2025** Status: **APPROVED** Date: **03/31/2025**

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F 0712 SS=D	Continued from page 43 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure a physician completed the initial visit for one of three residents (Resident R2). Findings include: Review of the facility policy "Physician Services" last reviewed 9/18/24, indicated the medical care is supervised by a licensed physician. Physician visits are provided in accordance with current OBRA (Omnibus Budget Reconciliation Act, also known as Nursing Home Reform Act of 1987, which set forth federal standards of how care should be provided to residents) regulation and facility policy. Review of Resident R2's clinical record indicated admission to the facility on 2/7/25, with diagnoses of anemia, bacteremia, and heart failure. Review of Resident R2's clinical record revealed a new patient visit was completed by Certified Registered Nurse Practitioner, Employee E17 on	F 0712		

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F 0712 SS=D	Continued from page 44 2/11/24. The facility failed to ensure the resident's initial visit was conducted by a physician. Review of Resident R2's clinical record revealed a history and physical visit completed by Medical Doctor, Employee E15 on 2/18/25. It was indicated the resident was not seen and was still in the hospital. During an interview on 3/13/25, at 1:18 p.m. the Medical Doctor, Employee E15 confirmed she failed to complete the initial visit for Resident R2. Medical Doctor, Employee E15 stated the regulation was not like that as far she knew. During an interview on 3/13/25, at 12:57 p.m. Certified Registered Practitioner, E18 confirmed CRNP, Employee E17 completed Resident R2's new patient visit on 2/11/25. During an interview on 3/13/25, at 1:24 p.m. the Director of Nursing confirmed the facility failed to ensure a physician completed the initial visit for one	F 0712		

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F 0712 SS=D	Continued from page 45 of three residents (Resident R2). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(5) Nursing services.	F 0712		
F 0835 SS=F		F 0835		

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F 0835 SS=F	Continued from page 46 483.70 Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 0835	F-835 Administration 1. The elopement assessment was rewritten by the Regional Clinical Director and Director of Nursing on March 13, 2025 The resident elopement books were updated by the Administrator and Director of Nursing on March 13, 2025. The Resident LOA Policy was updated on March 13, 2025, to include a system requiring the orders are reviewed before allowing the residents to leave the facility. 2. A Root Cause Analysis was completed by the Administrator on March 13, 2025, which identified four risk factors for future elopements. 3. An audit will be completed on each new admission by the Administrator or designee to assess each resident against the four risk factors identified in the Root Cause Analysis. These audits will be completed weekly for 3 weeks then monthly for 2 months. An audit will be completed by the Director of Nurses or designee to ensure that the elopement	Completion Date: **04/15/2025** Status: **APPROVED** Date: **04/01/2025**

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F 0835 SS=F	Continued from page 47	F 0835	assessments have been completed for new admissions, readmissions, quarterly, and change of condition. The audits will be completed weekly to ensure the LOA policy change is being properly implemented. This will be completed weekly for 3 weeks then monthly for 2 months. 4. A summary of the audits will be reviewed in the monthly QAPI meeting. The Regional Director of Operations and the Regional Clinical Director will meet with the Administrator and Director of Nursing to review the audit results and discuss any new issues that may impact safety in the facility. These meetings will take place weekly for 3 weeks and then monthly for 2 weeks.	

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F 0835 SS=F	Continued from page 48 Based on review of job descriptions, clinical records and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility to prevent the elopement of a resident (Resident R1), which created an immediate jeopardy situation for one of five residents. Findings include: The job description for the Nursing Home Administrator dated 10/29/24, specified the primary purpose of the job is to manage the facility in accordance with current applicable, federal, state, and local standards, guidelines, and regulations the govern long-term care facilities. It is the NHA job to follow all facility policies and to ensure the highest degree of quality care is provided to the residents at all times. The job description for the Director of Nursing dated 9/16/24, specified it is the responsibility of the DON to organize, develop, and direct the overall	F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395883	A. BLDG: __00_____ B. WING: _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BURGH CARE CENTER STATE LICENSE NUMBER: **016002**	**909 WEST STREET PITTSBURGH, PA 15221**

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F 0835 SS=F	Continued from page 49 operations of the Nursing Service Department in accordance with current federal, state and local standards, guidelines and regulations that govern the facility. Based on findings identified in this report, the facility failed to prevent the elopement of a resident (Resident R1), which placed the residents in Immediate Jeopardy. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 2/11/25, at 1:13 p.m. the NHA and DON were notified that they failed to effectively manage the facility to prevent the elopement of a resident, which created an immediate jeopardy situation for all residents. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.	F 0835		

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F 0835 SS=F	Continued from page 50	F 0835		
F 0841 SS=F	483.70(g)(1)(2) Responsibilities of Medical Director §483.70(g) Medical director. §483.70(g)(1) The facility must designate a physician to serve as medical director. §483.70(g)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by:	F 0841	F-841 Responsibilities of Medical Director 1. A specific Medical Director will be assigned to the facility by the Administrator or designee. 2. There are no other like individuals in this position in this facility to review. 3. The Medical Director will be educated by the Administrator or designee on regulation F-841. 4. The Director of Nursing and/or the Administrator will review facility clinical and operational areas weekly for 3 weeks and monthly for 2 months. A summary of these meetings will be reviewed in the monthly QAPI meetings for 2 months.	Completion Date: **04/15/2025** Status: **APPROVED** Date: **03/31/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0841 SS=F	Continued from page 51 Based on review of facility documents, and staff interviews it was determined the facility failed to designate a physician to serve as medical director. Findings Include: Review of the facility's medical director contract dated 12/1/23, signed by Doctor of Osteopathic Medicine (DO), Employee E14 indicated a medical group is to provide medical directorship and oversight services for the facility and to provide clinical medical services to the patients on each unit as medically necessary. It was stated the medical group agrees to assign "physicians" to provide such services. Review of information submitted to the Department of Health, on 3/12/25, at 1:30 p.m. revealed Medical Director, Employee E16 was the designated Medical Director of the facility since 1/1/20. During an interview on 3/12/25, at 2:47 p.m.	F 0841		

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F 0841 SS=F	Continued from page 52 Regional Clinical Specialist, Employee E9 stated Medical Director, Employee E15 works for a medical group. It was indicated she became the facility's Medical Director within the last seven to eight months. During an interview on 3/13/25, at 1:18 p.m. Medical Director, Employee E15 stated she took over in August of 2024. Medical Director, Employee E15 stated the medical group is the medical director of the facility. During an interview on 3/13/25, at 1:24 p.m. the Director of Nursing confirmed the facility failed to designate a physician to serve as medical director. 28 Pa. Code 211.2.(c)(2)(3)(4) Medical director.	F 0841		

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H 0008	51.3 (f) NOTIFICATION 51.3 Notification (f) If a health care facility is aware of a situation or the occurrence of an event at the facility which could seriously compromise quality assurance or patient safety, the facility shall immediately notify the Department in writing. The notification shall include sufficient detail and information to alert the Department as to the reason for its occurrence and the steps which the health care facility shall take to rectify the situation. This REGULATION is not met as evidenced by:	H 0008	0008 Notification 1. The required notification time period for this incident cannot be corrected. 2. Department of Health Event Reports for the past 30 days will be audited by the Administrator or designee against the required reporting time periods to determine the level of compliance. 3. The Administrator and Director of Nurses will be educated on regulation H-0008 by the Regional Clinical Specialist or designee. The Department of Health Event Reports will be audited for compliance with the correct time periods daily for 3 weeks and then monthly for 2 months. 4. Audits will be reviewed in the monthly QAPI meetings for 2 months.	Completion Date: **04/15/2025** Status: **APPROVED** Date: **03/31/2025**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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H 0008	Continued from page 1 Based on review of clinical record, incident reports and staff interview, it was determined that the facility failed to notify the State Survey Agency of an incident of elopement no later than two hours after the incident occurred for one of three residents (Resident R24). Findings include: Review of the facility "Accidents and Incidents-Investigating and Reporting" policy reviewed 9/1/24, indicated all incidents involving residents shall be investigated and reported to the administrator. Review of Resident R1's admission record indicated he was admitted on 2/21/25, with diagnoses of opioid abuse, alcohol abuse, psychoactive substance abuse, and cerebral infarction (commonly referred to as a stroke, occurs when the blood supply to the brain is interrupted, leading to a lack of oxygen and nutrients to brain cells.)	H 0008		

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H 0008	Continued from page 2 Review of information submitted to the Department of Health on 2/26/25, indicated on 2/25/25, Resident R1 had an unauthorized LOA from the facility around 2:15 p.m. It was indicated the supervisor saw the resident walking away from the property and heading towards the bus stop, and immediately notified the DON. It was indicated he was dressed in street clothes with a winter coat. Staff members searched the area around the facility and called the resident's listed phone number. It was indicated the number listed was a place he had been staying prior to hospitalization and has since been evicted. The resident was not located. On 3/12/25, at 12:46 p.m. Regional Clinical Specialist, Employee E9 confirmed the facility failed to complete an incident report and the facility failed to notify the State Survey Agency of an incident of elopement no later than two hours after the incident occurred for one of three residents (Resident R24).	H 0008		

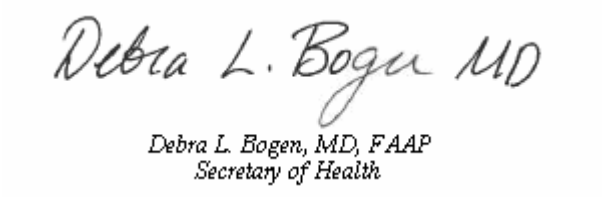
Certified End Page

BURGH CARE CENTER

STATE LICENSE NUMBER: 016002

SURVEY EXIT DATE: 03/13/2025

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



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY