STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396098	A. BLDG: 00 B. WING:	12/20/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
UPMC MAGEE-WOMENS HOSPITAL TRANSITIONAL CARE UNIT STATE LICENSE NUMBER: **65030201**	**300 HALKET STREET PITTSBURGH, PA 15213**

(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 Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance Survey completed on December 20, 2024, it was determined that UPMC Magee-Womens Hospital TCU 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 0690 SS=D		F 0690		

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 0690 SS=D	Continued from page 1 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 0690	R66 and R118 have been discharged. All current residents with catheters have been reviewed and appropriate care plans and orders have been entered to include size and amount of fluid needed. All RNs and LPNs will be educated by the Director of Nursing and/or designee that when a catheter is ordered or present, the MD order must state the appropriate size and fluid needed. There must also be care plans in place for all residents with catheters. The Director of Nursing and/or designee will review all residents with catheters present weekly for one month and monthly thereafter or until substantial compliance is achieved to ensure the MD order notes the appropriate size and fluid needed and that there is a care plan in place. Results will be reviewed at the Quarterly QAA meeting.	Completion Date: **01/28/2025** Status: **APPROVED** Date: **01/04/2025**

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F 0690 SS=D	Continued from page 2 This REQUIREMENT is not met as evidenced by:	F 0690		

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F 0690 SS=D	Continued from page 3 Based on review of facility policy, clinical records and staff interview, it was determined that the facility failed to ensure that the physician order for a urinary catheter (insertion of a tube into the bladder to remove urine) included the size of the foley catheter and the amount of fluid needed to insert for balloon inflation/securement (the balloon keeps catheter in the bladder) for two out of three sampled residents (Resident R66 and Resident R118) and failed develop a baseline care plan for the use of the foley catheter for one out of three residents (Resident R118). Findings include: The facility "Management of indwelling, intermittent, and external urinary catheters insertion care" policy last reviewed 8/1/24, indicated to provide the appropriate indications for inserting urinary catheters. Review of Resident R66's admission record indicated he was admitted 11/21/24.	F 0690		

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F 0690 SS=D	Continued from page 4 Review of Resident R66's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 11/28/24, indicated he had diagnoses that included thyroid disorder (decrease in production of thyroid hormone), Parkinson's disease (a disorder of the central nervous system which affects movement and includes tremors), and coronary artery disease (narrowing/blockage of vessels that carry blood and oxygen to the heart). The diagnoses were the most recent upon review. Section H (Bladder and Bowel) H0100A indicated an "X" for the use of an indwelling catheter. Review of Resident R66's care plans dated 11/21/24, indicated to provide elimination intervention and monitor output. Review of Resident R66's physician orders dated 12/16/24, indicated to insert foley catheter. Review of Resident R66's physician progress notes,	F 0690		

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F 0690 SS=D	Continued from page 5 other physician orders, nurse clinical notes, and certified nurse practitioner notes did not include the size of catheter in use. During observations on 12/18/24, at 7:37 a.m. observations of Resident R66 found him in bed resting, his foley catheter in place, and urinary catheter bag hanging on his bed. During observations on 12/20/24, at 8:57 a.m. observations of Resident R66 found him in bed resting, his foley catheter in place, and urinary catheter bag hanging on his bed. During an interview on 12/20/24, at 9:00 a.m. Registered Nurse (RN) Employee E2 confirmed that the facility failed to ensure that the physician order for a urinary catheter indicated the catheter size for Resident R66 as required. Review of Resident R118's clinical record indicates an admission date of 12/11/24, with the diagnosis of congestive heart failure (CHF- the heart doesn't	F 0690		

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F 0690 SS=D	Continued from page 6 pump blood as well as it should), atrial fibrillation (irregular and often rapid heartbeat), and chronic obstructive pulmonary disease (COPD-causes breathing problems and restricted airflow). Review of R118's physician order dated 12/17/24, indicated the resident has a foley catheter the order failed to include the size of the foley catheter or the amount of fluid needed to insert for balloon inflation/securement. Review of Resident R118's baseline care plan dated 12/11/24, failed to include care for the foley catheter. During an interview completed on 12/20/24, at 9:12 a.m. RN Employee E2 confirmed that the facility failed to ensure that the physician order for Resident R118's foley catheter included the size of the foley catheter and the amount of fluid needed to insert for balloon inflation/securement and the facility failed to ensure a care plan for the foley catheter was in place.	F 0690		

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F 0690 SS=D	Continued from page 7 28 Pa. Code: 211.5(f) Clinical records 28 Pa. Code: 211.12(c)(d)(1)(3)(5) Nursing services	F 0690		
F 0694 SS=D		F 0694		

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F 0694 SS=D	Continued from page 8 483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0694	R118 has been discharged. On the day of the findings residents with IVs were assessed to ensure dressing sites were labeled with a date and time, and that all dressings were intact without any signs or symptoms of complications. All RNs and LPNs will be educated by the Director of Nursing and/or designee that when an IV is in place, the dressing must be labeled appropriately with a date and time, and that all dressings should be inspected at least once a shift to ensure the dressing is intact and without any signs or symptoms of complications. The Director of Nursing and/or designee will audit all residents with an IV in place, to ensure that the dressing is labeled appropriately with a date and time, and that all dressings are being inspected at least once a shift to ensure the dressing is intact and without any signs or symptoms of complications.	Completion Date: **01/28/2025** Status: **APPROVED** Date: **01/04/2025**

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F 0694 SS=D	Continued from page 9	F 0694	Audits will be completed weekly for 4 weeks, then monthly for 2 months, or until substantial compliance is achieved. Results will be reviewed at the Quarterly QAA meetings.	

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F 0694 SS=D	Continued from page 10 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to provide adequate treatment and care for a peripherally inserted catheter (a thin plastic tube inserted into a vein using a needle) in accordance with professional standards of practice for one of two residents (Resident R118). Findings include: Review of the facility policy "Intravenous (IV) Therapy: Peripheral, Including Midlines" last reviewed 8/1/24, indicates to maintain venous access, administer continuous/intermittent intravenous fluids, nutrition, medications, and blood products over a specific time frame. All registered Nurses and Licensed Practical Nurses that complete the IV therapy program are responsible for including but not inclusive to: . IV site inspection a minimum of every shift. . Dressing changes for peripheral IV catheters. Site change is required for a contaminated IV or an IV showing signs and symptoms of complications.	F 0694		

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F 0694 SS=D	Continued from page 11 Peripheral IV site maintenance including but not inclusive to: . Maintain a clean, dry, and intact dressing over the insertion site. Review of Resident R118's clinical record indicates an admission date of 12/11/24, with the diagnosis of congestive heart failure (CHF- the heart doesn't pump blood as well as it should), atrial fibrillation (irregular and often rapid heartbeat), and chronic obstructive pulmonary disease (COPD-causes breathing problems and restricted airflow). Review of physician orders dated 12/17/24, indicated cefepime 1 gram intravenously every eight hours for seven days. During an observation on 12/18/24, at 8:49 a.m. Resident R118's right wrist peripheral intravenous (IV) access site was noted not to have been labeled with a date or time, the area of dressing under his wrist was observed lifting off and the center around the insertion site had noticeable dried blood.	F 0694		

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F 0694 SS=D	Continued from page 12 During an interview on 12/18/24, at 9:59 a.m. Registered Nurse (RN) Employee E3 confirmed the dressing did not contain a date or time of insertion, the dressing was lifting, and the center of dressing was noted to have dried blood. RN Employee stated "I will do a dressing change today" and confirmed that the facility failed to provide adequate treatment and care for a peripherally inserted catheter in accordance with professional standards of practice for one of two resident s (Resident R118). 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing Services. 28 Pa. Code: 201.14(a) Responsibility of licensee.	F 0694		
F 0695 SS=D		F 0695		

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F 0695 SS=D	Continued from page 13 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	R118 has been discharged. On the day of the findings, all residents with BIPAP/CPAP therapy were reviewed to ensure all BIPAP/CPAP masks not in use were in an equipment treatment bag with the residents last name, room number and date. All RNs and LPNs will be educated by the Director of Nursing and/or designee that when a BIPAP/CPAP machine is not in use that the mask should be placed in an equipment treatment bag with the residents last name, room number and date. The Director of Nursing and/or designee will audit BIPAP/CPAP equipment when not in use to ensure the BIPAP/CPAP mask is placed in an equipment treatment bad with the residents last name, room number and date. Audits will be completed weekly for 4 weeks, then monthly for 2 months, or until substantial compliance is achieved.	Completion Date: **01/28/2025** Status: **APPROVED** Date: **01/04/2025**

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F 0695 SS=D	Continued from page 14	F 0695	Results will be reviewed at the Quarterly QAA meeting.	

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F 0695 SS=D	Continued from page 15 Based on facility policy review, observations, and staff interviews, it was determined that the facility failed to maintain sanitary conditions of respiratory equipment for one of four residents reviewed (Resident R118). Findings include: Review of the facility policy "Respiratory Equipment Maintenance" dated 8/1/24, indicates to prevent the spread of nosocomial infections. BIPAP/CPAP (positive airway pressure ventilation system that helps a person breathe. Using a tightly fitted face mask to deliver the ventilation) should be changed as needed for soiling or equipment integrity. Remove old equipment and treatment bag. Label new patient belonging bag with patient's last name, room number, and date. Review of Resident R118's clinical record indicates an admission date of 12/11/24, with the diagnosis of congestive heart failure (CHF- the heart doesn't pump blood as well as it should), atrial fibrillation	F 0695		

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F 0695 SS=D	Continued from page 16 (irregular and often rapid heartbeat), and chronic obstructive pulmonary disease (COPD-causes breathing problems and restricted airflow). Review of Resident R118's physician orders dated 12/11/24, indicated BiPAP/non -invasive therapy at bedtime. During an observation on 12/18/24, at 9:52 a.m. Resident R118's fitted face mask was noted in a basket on a cart, the mask failed to be labeled and in a bag. During an interview completed on 12/18/24, at 10:02 a.m. Registered Nurse (RN) Employee E3 stated "respiratory therapy does a lot with the BIPAP, normally I would have it in its own bag and dated and confirmed that the facility failed to maintain sanitary conditions of respiratory equipment for one of four residents reviewed (Resident R118).	F 0695		

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	396098	A. BLDG: __00_____ B. WING: _____	12/20/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
UPMC MAGEE-WOMENS HOSPITAL TRANSITIONAL CARE UNIT STATE LICENSE NUMBER: **65030201**	**300 HALKET STREET PITTSBURGH, PA 15213**

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F 0695 SS=D	Continued from page 17 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing Services.	F 0695		
F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 18 483.45(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	The vial of eye drops, bottle of calcitonin nasal spray, polyvinyl eye drops and Lantus insulin were disposed of on 12/18/2024. The Nystatin powder and Hydrocortisone cream were placed in the treatment cart. On the day of the findings the remaining medication cart was inspected and no other open/undated items were found, and no other treatments were found in the medication cart. DON and/or designee will educate RNs and LPNs on the need to store medications and treatments separately to prevent cross contamination, and the need to label medications such as but not limited to eye drops and calcitonin spray when opened. DON and/or designee will audit medication/treatment carts and med rooms to ensure medications and treatments are stored separately to prevent cross contamination, and	Completion Date: **01/28/2025** Status: **APPROVED** Date: **01/04/2025**

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F 0761 SS=D	Continued from page 19	F 0761	that medications are labeled when opened. Audits will be completed weekly for 4 weeks, then monthly for 2 months, or until substantial compliance is achieved. Results of the audits will be reported at the Quarterly QAA meeting.	

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F 0761 SS=D	Continued from page 20 Based on review of facility policy, observation, and staff interview, it was determined that the facility failed to store medications and treatments for residents properly to prevent cross contamination for two of three medication carts (front hall medication cart and back hall medication cart) and failed to label medications upon opening for two of three medication carts (front Hall medication cart and back hall medication cart). Findings include: During an observation on 12/18/24, at 6:59 a.m. the front hall medication cart contained: . Two dispensing bottles of nystatin powder. . One tube of hydrocortisone cream. . One vial of brimonidine eye drops with no date opened. . One bottle of calcitonin nasal spray with no date opened. During an interview completed on 12/18/24, at 7:00 a.m. Registered Nurse (RN) Employee E5	F 0761		

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F 0761 SS=D	Continued from page 21 confirmed the above observations and stated, "we have a treatment cart". During an observation on 12/18/24, at 7:03 a.m. the back hall medication cart contained: . One tube of lidocaine and prilocaine (EMLA cream). . One tube of lidocaine gel. . One vial polyvinyl eye drops with no date opened. . One vial of Lantus insulin with no date open. During an interview on 12/18/24, at 7:06 a.m. RN Employee E5 confirmed the above observations and that the facility failed to store medications and treatments for residents properly to prevent cross contamination for two of three medication carts (front hall medication cart and back hall medication cart) and failed to label medications upon opening for two of three medication carts (front hall medication cart and back hall medication cart). 28 Pa. Code: 211.9(a)(1)(k) Pharmacy services.	F 0761		

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F 0761 SS=D	Continued from page 22 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0761		
F 0880 SS=E		F 0880		

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F 0880 SS=E	Continued from page 23 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Residents R65, R115, R118 and R123 were discharged. At the time of the findings all residents were assessed for the need to implement Enhanced Barrier Precautions (EBP) during high-contact resident care activities and a EBP order and care plan was initiated as indicated. At the time of the findings Employee E4 and all staff on duty were reminded to wash their hands after doffing soiled gloves and prior to donning a new pair of gloves during dressing changes to prevent cross contamination. Facility policies HS-IC0609 and SRC-Infection Control-2.1 Transmission Based Precautions-A were reviewed and verified to include EBPs. All RNs, LPNs and CNAs will be educated by the Administrator and/or designee to use EBPs during high-contact care activities for residents with: 1. Indwelling Medical Devices (such as but not limited to central line,	Completion Date: **01/28/2025** Status: **APPROVED** Date: **01/04/2025**

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F 0880 SS=E	Continued from page 24 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	urinary catheter, feeding tube, tracheostomy/ventilator), and when they should be implemented for residents. 2. Wounds 3. Colonization or Infection with a MDRO (Multi-Drug Resistant Organism). DON and/or designee to provide all RNs and LPNs education regarding the need to wash their hands after doffing soiled gloves and prior to donning a new pair of gloves during dressing changes to prevent cross contamination. NHA and/or designee will audit/observe 4 residents per week to ensure EBPs are being implemented during high-contact resident care activities, and that there is an MD order and a care plan in place as indicated. Audits will be conducted weekly for 4 weeks, then monthly for 2 months or until substantial compliance is obtained. DON and/or designee will	

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F 0880 SS=E	Continued from page 25	F 0880	audit/observe 4 dressing changes per week to ensure RN and/or LPN providing care, wash their hands after doffing soiled gloves and prior to donning a new pair of gloves during dressing changes to prevent cross contamination. Audit will be completed weekly for 4 weeks, then monthly for 2 months or until substantial compliance is obtained. The results will be reviewed at the Quarterly QAA meetings.	

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F 0880 SS=E	Continued from page 26 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to implement Enhanced Barrier Precautions (EBP) for four of eleven residents (Resident R65, R115, R118 and R123), and failed to implement infection control practices to prevent cross contamination during a dressing change for one of three residents (Resident R65). Findings include: The Centers for Disease Control defines Enhanced Barrier Precautions (EBP) as: an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. EBP involve gown and gloves during high-contact resident care activities for residents known to be colonized or infected with MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Review of the facility policy "Transmission-Based	F 0880		

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F 0880 SS=E	Continued from page 27 Isolation and Standard Precaution Policy" dated 10/4/24, Types of transmission based precautions did not include Enhanced Barrier Precautions. Review of the facility policy "Wound Care" last reviewed 8/1/23, indicates dressings are changed daily and as needed. Maintain aseptic technique during dressing change. Procedure includes but not inclusive to: . Remove dressing, discard the dressing and gloves. . Wash hands. . Apply gloves. Review of Resident R65's clinical record indicates an admission date of 12/10/24, with the diagnosis of right humerus fracture (long bone of upper arm), anxiety and panic disorder. Review of a physician order dated 12/13/24, indicated Resident R65 had a surgical wound to her right arm.	F 0880		

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F 0880 SS=E	Continued from page 28 Review of Resident R65's clinical record on 12/18/24, failed to reveal an order or care plan for Enhanced Barrier Precautions in relation to Resident R65's surgical wound. Review of Resident R115's clinical record indicates an admission date of 12/16/24, with the diagnosis of coronary artery disease (CAD- a buildup of plaque in the arteries that reduces blood flow to the heart) hypertension (high blood pressure) cholecystitis (inflammation of the gallbladder). During an observation on 12/18/24, at 08:55 a.m. a bulb shaped device connected to a tube was noted to be inserted into Resident R115' s right lower abdomen. Review of Resident R115's physician orders dated 12/16/24, indicated pigtail catheter, empty and record daily, flush with 10cc (cubic centimeter) of normal saline every 12 hours. Review of Resident R115's clinical record on	F 0880		

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F 0880 SS=E	Continued from page 29 12/18/24, failed to reveal an order or care plan for Enhanced Barrier Precautions in relation to Resident R115's pigtail catheter. Review of Resident R118's clinical record indicates an admission date of 12/11/24, with the diagnosis of congestive heart failure (CHF- the heart doesn't pump blood as well as it should), atrial fibrillation (irregular and often rapid heartbeat), and chronic obstructive pulmonary disease (COPD-causes breathing problems and restricted airflow). Review of a physician order dated 12/17/24, indicated foley catheter. Review of Resident R118's clinical record on 12/18/24, failed to reveal an order or care plan for Enhanced Barrier Precautions in relation to Resident R115's foley catheter. Review of Resident R123's clinical record indicates an admission date of 12/17/24, with the diagnosis of left hip arthroplasty, atrial fibrillation, and	F 0880		

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F 0880 SS=E	Continued from page 30 hyperlipidemia (high fat in the blood). During an interview completed on 12/18/24, at 8:24 a.m. Resident R123 stated she was new to the facility and had recent left hip surgery. Review of Resident R123's care plan on 12/18/24, indicated potential for wound/incisional infection. Review of Resident R123's clinical record on 12/18/24, failed to reveal an order or care plan for Enhanced Barrier Precautions in relation to Resident R123's surgical incision. During an interview completed on 12/18/24, at 12:34 p.m. the Director of Nursing stated "all the doors have bins and a stop see nurse sign, the stop sign is meant for dietary, we have separate signs for the other precautions in a clear sleeve next to the door, there are no enhanced barrier signs, no enhanced barrier precautions are being used and enhanced barrier precautions are not in any care plans, I am going to put all the care plans in, that ' s	F 0880		

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F 0880 SS=E	Continued from page 31 what being a nurse is". During an interview completed on 12/19/24, at 10:52 a.m. the Infection Preventionist Employee E1 stated "I have never heard of enhanced precautions, were not aware that was a new piece added to infection control, I am going to make a recommended to the hospital system to add it to the policy. I am going to add it to the infection control plan/policy for this unit as well". During an observation on 12/19/24 at 11:44 a.m. of a dressing change for Resident R65 the following cross contamination opportunities were observed. Licensed Practical Nurse (LPN) Employee E4 removed Resident R65's soiled dressings, removed gloves, did not complete hand hygiene and applied new gloves. Employee E4 continued to cleanse wounds, patted wounds dry, applied adaptic (non adherent dressing) , removed gloves, did not complete hand hygiene and applied new gloves. LPN Employee E4 continued to apply the adaptic to second and third areas removing gloves in	F 0880		

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UPMC MAGEE-WOMENS HOSPITAL TRANSITIONAL CARE UNIT STATE LICENSE NUMBER: **65030201**	**300 HALKET STREET PITTSBURGH, PA 15213**

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F 0880 SS=E	Continued from page 32 between and not completing hand hygiene prior to donning new gloves. LPN Employee E4 applied the ABD pads (highly absorbent dressings that provide padding and protection) removed gloves, did not complete hand hygiene, applied new gloves, applied the kerlix wrap and secured with tape. During an interview completed on 12/19/24, at 12:15 p.m. LPN Employee E4 confirmed she failed to implement infection control practices to prevent cross contamination during a dressing change for Resident R65 by not completing hand hygiene after removal of gloves and donning of new gloves for one of three residents (Resident R65). 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12 (d)(1)(2)(3) Nursing Services.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396098	A. BLDG: 00 B. WING:	12/20/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
UPMC MAGEE-WOMENS HOSPITAL TRANSITIONAL CARE UNIT STATE LICENSE NUMBER: **65030201**	**300 HALKET STREET PITTSBURGH, PA 15213**

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P 1020	Responsibility of licensee. (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other Federal, State and local agencies responsible for the health and welfare of residents. This includes complying with all applicable Federal and State laws, and rules, regulations and orders issued by the Department and other Federal, State or local agencies. This REGULATION is not met as evidenced by:	P 1020	A new community member representative has been identified. An individual meeting with the new Infection Control Committee Meeting community member representative has been coordinated to provide a summary of the last meeting and the next meeting date. The NHA has re-educated the Infection Prevention Coordinator regarding the need to have a community member at the quarterly Infection Control Committee Meeting, and the need to confirm availability and attendance in advance of the meeting date. Audits will be completed monthly by the NHA and/or designee to ensure a meeting invite has been sent to the community member representative. Attendance will be confirmed following each quarterly meeting. Audits will be completed for 2 meetings or until substantial compliance is achieved. Results will be reviewed at the quarterly QAA meeting.	Completion Date: **01/28/2025** Status: **APPROVED** Date: **01/04/2025**

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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P 1020	Continued from page 1 Based on state regulations, staff interview, and review of the facility's Infection Control Meeting attendance records, it was determined that the facility failed to ensure that all of the required nine multidisciplinary members were present at the Infection Control Meetings (a member from the community) for four of four quarters (Quarter 1, Quarter 2, Quarter 3, and Quarter 4). Findings include: Review of Act 52 (The Act of March 20, 2002, P.L. 154, No. 13), known as the Medical Care Availability and Reduction of Error (MCARE) Act, Chapter 4, Section 403(1) Infection Control plan states, "A health care facility... shall develop and implement an internal infection control plan that shall include... a multidisciplinary committee including representatives from each of the following if applicable to that specific health care facility." A review of the applicable members at infection control meetings includes medical staff, administration, laboratory personnel, nursing staff,	P 1020		

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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P 1020	Continued from page 2 pharmacy staff, physical plan personnel, patient safety officer, a community member, and a member of the infection control team. Review of the facility's Infection Control Meeting attendance records for Quarter 1 (January 2024, February 2024, March 2024), Quarter 2 (April 2024, May 2024, June 2024), Quarter 3 (July 2024, August 2024, September 2024), and Quarter 4 (October 2024, November 2024, and December 2024), failed to reveal that a member from the community was in attendance. During an interview on 12/19/24, at 10:52 a.m. the Infection Preventionist Employee E1 confirmed that the facility failed to ensure that all of the required nine multidisciplinary members were present at the Infection Control Meetings for four of four quarters.	P 1020		

Certified End Page

UPMC MAGEE-WOMENS HOSPITAL TRANSITIONAL CARE UNIT

STATE LICENSE NUMBER: 65030201

SURVEY EXIT DATE: 12/20/2024

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

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

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY