

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 395434	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2020
NAME OF PROVIDER OF SUPPLIER MT LEBANON REHABILITATION AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP 350 OLD GILKESON ROAD PITTSBURGH, PA 15228	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0880 Level of harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, facility policies, clinical review, observations and staff interviews, it was determined that the facility failed to implement universal testing in the timing outlined in PA HAN 509 for 20 of 95 residents (R1, R2, R3). Findings include: Facility policy COVID-19 Control Management Plan dated 3/2/20, indicated that the facility used the CDC Flowchart - Assess and Identify for [MEDICAL CONDITION] as a guide for assessment and decision making. Review of the Pennsylvania Health Alert Network (PA HAN) 509, released on 6/1/20, indicated if there is a new confirmed case of COVID-19 in the facility, testing of all residents and Healthcare Personnel (HCP) in the facility is to be implemented, even if baseline testing has been completed in the past. If there is a suspect case and test results for the suspect case are anticipated to take longer than 2-3 days, the facility does not wait to conduct mass testing; the facility begins planning and executes testing of all residents and HCP while awaiting results. A review of Resident R1's admission record indicated that resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the clinical record and the Quarterly Minimum Data Set (MDS - periodic assessment of care needs) dated 7/27/20, indicated that these [DIAGNOSES REDACTED]. The facility did not test residents or staff. A review of Resident R2's admission record indicated that he was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the clinical record and the MDS dated [DATE], indicated these [DIAGNOSES REDACTED]. The facility did not test residents or staff. A review of Resident R3's admission record indicated that he was admitted on [DATE], with [DIAGNOSES REDACTED]. Review of the clinical record and the MDS dated [DATE], indicated that these [DIAGNOSES REDACTED]. The facility did not test residents or staff. During an interview on 8/20/20, at 10:00 a.m. the Nursing Home Administrator confirmed that Resident R1 became symptomatic with fatigue, chills, and diminished lung sounds on 8/1/20, and the facility failed to test Resident R1 for the COVID-19 virus. Residents R2 and R3 were tested on [DATE] with positive results on 8/6/20, and the facility failed to begin planning/executing testing of all residents and staff until 8/11/20. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies.		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

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