STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395034	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vincentian Home	111 Perrymont Road Pittsburgh, PA 15237

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, documents, clinical records, and staff and resident interviews it was determined was determined that the facility failed to protect resident from neglect for one of three residents (Residents R1). Findings include: Review of the facility policy Freedom from Abuse, Neglect, and Exploitation last reviewed 3/19/25, stated it is the policy of the facility to maintain an environment where residents are free from abuse, neglect, and misappropriation of resident property. Neglect is defined as the failure of the facility, its employees or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Review of the facility policy Resident Transfer Protocol last reviewed 3/19/25, stated appropriate transfer techniques shall be used according to each resident's strength, stamina, and ability to assist with the residents. Necessity for the amount and type of assistance shall be assessed upon admission and on an ongoing basis. Review of the facility policy Falls and Falls with Major Injury last reviewed 3/19/25, stated all facility staff is responsible for implementing the intent and directives contained within this policy, and for creating a safe environment of care. It is the facility's policy to minimize the risk of falling, and injuries sustained from falls, without compromising the mobility and functional independence of residents. Review of Residents R1's admission record indicated the resident was admitted on [DATE], and readmitted [DATE], with diagnoses of muscle wasting and atrophy, muscle weakness, and abnormalities of gait and mobility. Review of Residents R1's care plan dated 11/28/22, revised 3/6/25, revealed the resident required a full body (Hoyer) mechanical and a two person assist for transfers and all hygiene and repositioning while the resident is in bed. Review of Residents R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/18/25, indicated the diagnoses were current. Section GG- Functional Abilities revealed the resident was dependent with rolling left to right and required the assistance of two or more helpers. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician order dated 4/12/25, revealed Resident R1 required assistance of two persons with bed positioning, hygiene, and transfers. Review of Resident R1's progress note dated 5/3/25, entered at 8:45 a.m., by Registered Nurse (RN) Employee E4 revealed Nurse Aide (NA) Employee E1 reported Resident R1 was on the floor and needed assistance. It was stated the NA Employee E1 was performing care when the resident rolled out of bed. The resident was observed lying on their right side with their head up against night stand. The resident had a partial head laceration and complained of a headache. The resident was transferred to hospital for further evaluation. Review of information submitted to the State Agency on 5/5/25, indicated on 5/3/25, Resident R1 was found to be incontinent of a large bowel movement. NA Employee E1 was providing care for the resident. As the aide rolled the resident the aide lost their balance. The resident rolled to the floor and sustained a fall. The nurse assessed the resident and a small laceration was observed on the resident's right side of head. The resident was sent to the hospital and returned with no new orders. Review of the facility's investigation on 6/25/25, revealed NA Employee E1's witness statement that stated Resident R1 had a bowel movement and NA Employee E1 went to change the resident. NA Employee E1 stated Typically I always get help but I just wasn't thinking that morning. The resident rolled out of bed. Review of Resident R1's witness statement on 6/25/25, revealed when NA Employee E1 rolled the resident, Resident R1 fell of the bed. It was indicated NA Employee E1 rolled Resident R1 away from themselves. During an attempted phone interview on 6/25/25, at 10:00 a.m. NA Employee E1 was unavailable. During an interview on 6/25/25, at 10:12 a.m. Licensed Practical Nurse (LPN) Employee E2 stated the nurse aides can find a resident's transfer status from the Kardex (a documentation system that enables nurses to write, organize, and easily reference key patient information that shapes their nursing care plan) and report sheets. Nurse aides are expected get assistance for residents who require assistance of two persons. During an interview on 6/25/25, at 10:14 a.m. Resident R1 stated everything happened so fast when asked about the fall that occurred on 5/3/25. Resident R1 stated I rolled out of bed while getting changed. During an interview on 6/25/25, at 10:28 a.m. NA Employee E3 stated if a resident is ordered to be transferred with an assist of two, then two people must assist the resident with bed mobility. NA Employee E3 stated I would wait, I don't want to drop anyone. During an interview on 6/25/25, at 12:41 p.m. the Nursing Home Administrator and Director of Nursing confirmed the facility failed to protect residents from neglect for one of three residents (Residents R1). 28 Pa. Code: 201.14(a) Responsibility of licensee. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code: 201.18(e)(1) Management. 28 Pa. Code: 207.2(a) Administrator's responsibility. 28 Pa. Code: 211.10(d) Resident care policies.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical records, and staff and resident interviews it was determined the facility failed to report an incident of neglect within 24 hours to the local state field office for one of three residents (Residents R1). Findings include: Review of the facility policy Incident-Clinical Protocol last reviewed 3/19/25, stated anyone who witnesses, discovers or is involved in an incident is responsible for reporting to the Licensed Nurse on the unit as soon as possible, on the day of discovery. In the event, that it was determine the :incident was reportable to the State Agency , it will be done timely and submitted by the Director of Nursing or Designees. Review of the facility policy Freedom from Abuse, Neglect, and Exploitation last reviewed 3/19/25, stated it is the policy of the facility to maintain an environment where residents are free from abuse, neglect, and misappropriation of resident property. Neglect is defined as the failure of the facility, its employees or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The Administrator or designee will make an initial (immediate or within 24 hours) report to the State Agency. Review of Residents R1's admission record indicated the resident was admitted on [DATE], and readmitted [DATE], with diagnoses of muscle wasting and atrophy, muscle weakness, and abnormalities of gait and mobility. Review of Residents R1's care plan dated 11/28/22, revised 3/6/25, revealed the resident required a full body (Hoyer) mechanical and a two person assist for transfers and all hygiene and repositioning while the resident is in bed. Review of Residents R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/18/25, indicated the diagnoses were current. Section GG- Functional Abilities revealed the resident was dependent with rolling left to right and required the assistance of two or more helpers. Review of physician order dated 4/12/25, revealed Resident R1 required assistance of two persons with bed positioning, hygiene, and transfers. Review of Resident R1's progress note dated 5/3/25, entered at 8:45 a.m., by Registered Nurse (RN) Employee E4 revealed Nurse Aide (NA) Employee E1 reported Resident R1 was on the floor and needed assistance. It was stated the NA Employee E1 was performing care when the resident rolled out of bed. The resident was transferred to hospital for further evaluation. Review of information submitted to the State Agency on 5/3/25, and 5/4/25, failed to include Resident R1's incident of neglect. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/25, at 12:41 p.m. the Nursing Home Administrator and Director of Nursing confirmed the facility failed to report an incident of neglect within 24 hours to the local state field office for one of three residents (Residents R1).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, documents, clinical records, and staff and resident interviews it was determined that the facility failed to ensure the appropriate assistance for bed mobility was provided to prevent a roll out of bed for one of five residents (Residents R1). Findings include: Review of the facility policy Resident Transfer Protocol last reviewed 3/19/25, stated appropriate transfer techniques shall be used according to each resident's strength, stamina, and ability to assist with the residents. Necessity for the amount and type of assistance shall be assessed upon admission and on an ongoing basis. Review of the facility policy Falls and Falls with Major Injury last reviewed 3/19/25, stated all facility staff is responsible for implementing the intent and directives contained within this policy, and for creating a safe environment of care. It is the facility's policy to minimize the risk of falling, and injuries sustained from falls, without compromising the mobility and functional independence of residents. Review of Residents R1's admission record indicated the resident was admitted on [DATE], and readmitted [DATE], with diagnoses of muscle wasting and atrophy, muscle weakness, and abnormalities of gait and mobility. Review of Residents R1's care plan dated 11/28/22, revised 3/6/25, revealed the resident required a full body (Hoyer) mechanical and a two person assist for transfers and all hygiene and repositioning while the resident is in bed. Review of Residents R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/18/25, indicated the diagnoses were current. Section GG- Functional Abilities revealed the resident was dependent with rolling left to right and required the assistance of two or more helpers. Review of physician order dated 4/12/25, revealed Resident R1 required assistance of two persons with bed positioning, hygiene, and transfers. Review of Resident R1's progress note dated 5/3/25, entered at 8:45 a.m., by Registered Nurse (RN) Employee E4 revealed Nurse Aide (NA, Employee E1 reported Resident R1 was on the floor and needed assistance. It was stated the NA Employee E1 was performing care when the resident rolled out of bed. The resident was observed lying on their right side with their head up against night stand. The resident had a partial head laceration and complained of a headache. The resident was transferred to hospital for further evaluation. Review of information submitted to the State Agency on 5/5/25, indicated on 5/3/25, Resident R1 was found to be incontinent of a large bowel movement. NA Employee E1 was providing care for the resident. As the aide rolled the resident the aide lost their balance. The resident rolled to the floor and sustained a fall. The nurse assessed the resident and a small laceration was observed on the resident's right side of head. The resident was sent to the hospital and returned with no new orders. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation on 6/25/25, revealed NA Employee E1's witness statement that stated Resident R1 had a bowel movement and NA Employee E1 went to change the resident. NA Employee E1 stated Typically I always get help but I just wasn't thinking that morning. The resident rolled out of bed. Review of Resident R1's witness statement on 6/25/25, revealed when NA Employee E1 rolled the resident, Resident R1 fell of the bed. It was indicated NA Employee E1 rolled Resident R1 away from themselves. During an interview on 6/25/25, at 10:12 a.m. Licensed Practical Nurse (LPN) Employee E2 stated the nurse aides can find a resident's transfer status from the Kardex (a documentation system that enables nurses to write, organize, and easily reference key patient information that shapes their nursing care plan) and report sheets. Nurse aides are expected get assistance for residents who require assistance of two persons. During an interview on 6/25/25, at 10:14 a.m. Resident R1 stated everything happened so fast when asked about the fall that occurred on 5/3/25. Resident R1 stated I rolled out of bed while getting changed. During an interview on 6/25/25, at 10:28 a.m. NA Employee E3 stated if a resident is ordered to be transferred with an assist of two, then two people must assist the resident with bed mobility. NA Employee E3 stated I would wait, I don't want to drop anyone. During an interview on 6/25/25, at 12:42 p.m. the Nursing Home Administrator and Director of Nursing confirmed the facility failed to ensure the appropriate assistance for bed mobility was provided for one of five residents (Residents R1), which resulted in a fall. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(e)(1) Management.