STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395688	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Village of South HI	1290 Boyce Road Pittsburgh, PA 15241

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. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395688	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2025
NAME OF PROVIDER OR SUPPLIER Friendship Village of South HI		STREET ADDRESS, CITY, STATE, ZIP CODE 1290 Boyce Road Pittsburgh, PA 15241	

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and documents, clinical record review, and staff interviews, it was determined that the facility failed to protect residents from neglect that resulted in the actual harm of a skin tear that required 17 sutures for one of three residents (Resident R3). Findings include: Review of the facility policy Abuse, Neglect, and Exploitation dated 8/13/25, indicated, The facility will provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse common to collect, exploitation and misappropriation of resident property. Neglect was defined as, As the failure of the facility, its employees, or service 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 Activities of Daily Living, Supporting dated 8/13/25, indicated, Appropriate care and services will be provided for residents who are unable to carry out ADLs (Activities of Daily Living) independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:a) Hygiene b) Mobility c) Elimination d) Dining e) Communication Review of the clinical record indicated Resident R3 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 8/27/25, included diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), heart failure (a progressive heart disease that affects pumping action of the heart muscles) and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of Section GG: indicated that Resident R3 was dependent on staff (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for Chair/bed-to-chair transfer. Review of a physician order dated 8/24/25, indicated Pt (patient) to transfer with assist of 2. Review of Resident R3's plan of care for Potential/actual skin impairment intervention dated 8/22/25, indicated Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Review of Resident R3's Kardex (document that outlines the patients' ADLs, continence levels, and behaviors, as well as physician, advanced directives, diet, and allergies) utilized by nurse aide staff dated 9/18/22, indicated Transfer with assist x2. NWB to LLE (non-weight bearing to left lower extremity). Review of a progress note dated 9/19/25, at 3:45 p.m. indicated, CNA (nurse aide) told this nurse that resident got a deep skin tear on right lower leg she noticed after transferring her from wheelchair to bed and pants were off. This nurse went into room and seen large deep skin tear on right shin area with moderate amount of blood dripped down resident's leg. Resident states she felt her leg rub on something when she was being transferred from wheelchair to bed but it did not hurt. She noticed her leg was bleeding after her pants were taken off after getting into bed. Cleaned right shin wound with saline and measured it. Bleeding was stopped right after arriving into room. Skin tear is shaped like a 90 degree angle; one side 4.5cm, the other side 5cm, 1cm wide, and 1cm deep with a fatty flap of skin. This nurse had 2 other nurses assess skin tear and recommended she be sent to hospital. [Physician] and daughter notified. Skin tear was cleaned with saline and dressed with Xeroform (fine mesh gauze), 4x4's, and wrapped with Kerlix (absorbent rolled bandage). Resident had no complaints of pain or discomfort. Alert and vitals stable. Review of facility submitted information dated 9/20/25, indicated that on 9/19/25, CNA transferred patient from wheelchair to bed, went to get a gown for the patient and noted a skin tear to right lateral shin, notified nursing. RN (registered nurse) supervisor assessed and right lateral skin tear measuring 4.5cm x 5cm x 1cm, exposure of adipose tissue. Cleansed right lateral shin with nss, applied xeroform and covered with pressure dressing. Pt is a 2-assist transfer and was transferred with 1 assist. CNA was sent home and not to return until investigation completed. Upon investigation, it noted that while pt was being transferred hit her right shin off of wheelchair leg rest holder as it aligns with skin tear to right lateral shin. No sharp areas noted to bed frame. MD notified and ordered to send patient to hospital for evaluation. Daughter notified. APS (Adult Protective Services) notified at 440pm. Pt returned from hospital at approximately 11:49 pm with 17 sutures and a wound care orders. Review of an employee statement written by NA Employee E4 dated 9/19/24, indicated, On Friday, September 19, 2025 I went into [Resident R3's] room to answer her call light. She wanted to get in bed so I stood her up. She pivoted then sat on the bed. I put her feed in then went to get a nightgown. When I came back she showed me the skin tear and said get the nurse. She was not aware how it happened and I was not

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and documents, clinical record review, and staff interviews, it was determined that the facility failed to provide adequate supervision to prevent falls that resulted in the actual harm of a skin tear that required 17 sutures for one of three residents (Resident R3). This was identified as past non-compliance. Findings include: Review of the facility policy Activities of Daily Living, Supporting dated 8/13/25, indicated, Appropriate care and services will be provided for residents who are unable to carry out ADLs (Activities of Daily Living) independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:a) Hygiene b) Mobility c) Elimination d) Dining e) Communication Review of the clinical record indicated Resident R3 was originally admitted to the facility on [DATE], and readmitted on [DATE]. 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Review of Resident R3's plan of care for Potential/actual skin impairment intervention dated 8/22/25, indicated Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Review of Resident R3's Kardex (document that outlines the patients' ADLs, continence levels, and behaviors, as well as physician, advanced directives, diet, and allergies) utilized by nurse aide staff dated 9/18/22, indicated Transfer with assist x2. NWB to LLE (non-weight bearing to left lower extremity). Review of a progress note dated 9/19/25, at 3:45 p.m. indicated, CNA (nurse aide) told this nurse that resident got a deep skin tear on right lower leg she noticed after transferring her from wheelchair to bed and pants were off. This nurse went into room and seen large deep skin tear on right shin area with moderate amount of blood dripped down resident's leg. Resident states she felt her leg rub on something when she was being transferred from wheelchair to bed but it did not hurt. She noticed her leg was bleeding after her pants were taken off after getting into bed. Cleaned right shin wound with saline and measured it. Bleeding was stopped right after arriving into room. Skin tear is shaped like a 90 degree angle; one side 4.5cm, the other side 5cm, 1cm wide, and 1cm deep with a fatty flap of skin. This nurse had 2 other nurses assess skin tear and recommended she be sent to hospital. [Physician] and daughter notified. Skin tear was cleaned with saline and dressed with Xeroform (fine mesh gauze), 4x4's, and wrapped with Kerlix (absorbent rolled bandage). Resident had no complaints of pain or discomfort. Alert and vitals stable. Review of facility submitted information dated 9/20/25, indicated that on 9/19/25, CNA transferred patient from wheelchair to bed, went to get a gown for the patient and noted a skin tear to right lateral shin, notified nursing. RN (registered nurse) supervisor assessed and right lateral skin tear measuring 4.5cm x 5cm x 1cm, exposure of adipose tissue. Cleansed right lateral shin with nss, applied xeroform and covered with pressure dressing. Pt is a 2-assist transfer and was transferred with 1 assist. CNA was sent home and not to return until investigation completed. Upon investigation, it noted that while pt was being transferred hit her right shin off of wheelchair leg rest holder as it aligns with skin tear to right lateral shin. No sharp areas noted to bed frame. MD notified and ordered to send patient to hospital for evaluation. Daughter notified. APS (Adult Protective Services) notified at 440pm. Pt returned from hospital at approximately 11:49 pm with 17 sutures and a wound care orders. Review of an employee statement written by NA Employee E4 dated 9/19/24, indicated, On Friday, September 19, 2025 I went into [Resident R3's] room to answer her call light. She wanted to get in bed so I stood her up. She pivoted then sat on the bed. I put her feed in then went to get a nightgown. When I came back she showed me the skin tear and said get the nurse. She was not aware how it happened and I was not aware she hit her leg on anything. Review of a facility submitted Report Form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property dated 9/29/25, included the information, CNA received 1:1 (one on one) training prior to the start of her shift on understanding the importance of checking a residents transfer status prior to attempting to transfer a resident. CNA was also educated on safe transfers. Review of a Team Member Counseling Notice dated 9/24/25, indicated, On 9/19