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	04/24/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of facility policy, clinical record reviews and staff interviews, it was determined that the facility failed to initiate a thorough investigation to rule out physical abuse or neglect for one of three residents (discharged Resident R1). Findings include: Review of the facility policy Freedom from Abuse, Neglect, and Exploitation last reviewed 3/23/26, indicated to maintain an environment where residents are free from abuse, neglect, exploitation and misappropriation of resident's property. All residents, staff, families, visitors, volunteers and resident representatives are encouraged to report and suspected acts of abuse, neglect, misappropriation of resident property or exploitation. The facility must take the following actions in response to an alleged violation of abuse, neglect, exploitation or mistreatment:Thoroughly investigate the alleged violationPrevent further abuse, neglect, exploitation and mistreatment from occurring while the investigation is in progressTake appropriate corrective, because of investigation findings.Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental or physical condition, cause physical harm, pain or mental anguish. Review of the clinical record indicated discharged Resident R1 was admitted to facility on 2/12/26. Review of discharged Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/9/26, indicated diagnoses of high blood pressure, Benign Prostatic Hyperplasia (prostate gland enlargement that can cause urinary difficulty), and muscle wasting and atrophy of multiple cites (loss of muscle tissue). Review of discharged Resident R1's physician order dated 3/18/26, indicated transfers x1 with wheeled walker. Review of the facilities grievance log encounter form dated 4/1/26, indicated the following:Category: StaffingConcern: Spouse reports Nurse Aid (NA) exhibiting rude behavior.Steps taken/Summary/Corrective Action: Director of Nursing investigated and found concerns unsubstantiated.Date resolved: 4/1/26. Review of the facility provide grievance form dated 4/1/26, completed by discharged Resident R1's wife indicated:Incident 1: When resident used call bell the NA was very sharp and rude: what do you want and said someone will help you (with toileting). She left the room and did not return for 2 hours. After the resident used call light.Incident 2: NA grabbed discharged Resident R1's right arm to re-position him, again during toileting. A bruise was evident on right forearm.Further documentation on grievance form: The NA has been rude and disrespectful, impatient and inattentive on several other occasions during toileting needs. She scolded him for being wet when he was made to wait for assistance for an unreasonable amount of time. Review of the facilities provided statements revealed the following: Nurse Aid Employee E5's statement dated 4/1/26, revealed discharged Resident R1 asked to use the restroom. In his assistance of daily (ADL's) living sheet it is stated he is considered a two-person transfer. I requested the nurse to assist she never came upon my request. Due to the lack of help for the two person transfer I informed the resident that he would have to utilize a bed pan; the resident did show irritation. I communicated and informed him that due to his ADL's it was not safe to move him with one NA no other communication was conducted, no complaints were made at that time.An interview completed by Director of Nursing (DON) on 4/1/26, at 6:00 p.m. He made the statement that she was not nice and rude, did not respect him. Two weeks ago, she was rough and grabbed his arm (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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and caused a bruise, which hurt. Her attitude was dismissing of him. He got to the point where he no longer wanted to tolerate her.On 4/2/26, the Nursing Home Administrator (NHA) went to speak with resident and wife. Wife requested that the NA not care for her husband. The NHA informed wife and resident that allegations are taken seriously and will follow up.On 4/4/26, a statement was completed by Registered Nurse Employee E8, I wasn't informed or aware of anything that had transpired. No NA on duty has reported to me about any resident being abused by staff. During an interview completed on 4/23/26, at approximately 2:00 p.m. The Director of Nursing (DON) confirmed that no other residents were interviewed that the Nurse Aid took cared for, no other staff interviews were completed and stated, the claim was only on this Nurse Aid so we only looked at her. During an interview completed on 4/23/26, at 11:45 a.m. the Nursing Home Administrator stated the family filed a grievance, it was investigated and completed, their complaint was they just didn't like NA Employee E5 and preferred not to have her. We got statements. NA Employee E5 deflected the allegation onto other employees, it was her, she never returned any further calls she was not cooperative. NA Employee E5 was self-terminated due to lack of response to the facility. When asked if other staff members or residents were interviewed concerning physical/verbal abuse or neglect stated, at what point do you stop the investigation? and confirmed that the facility failed to initiate a thorough investigation to rule out physical abuse or neglect for one of three residents (discharged Resident R1). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18 (b)(1) Management.28 Pa. Code: 211.10 (c)(d) Resident Care policies.28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for one of three residents (discharged Resident R1) and failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for three of three resident hospital transfers (discharged Resident R1, discharged Resident R2 and Resident R3).Findings include: Review of facility policy Resident Notice of Transfer or Discharge last reviewed 3/23/26, indicated before this facility transfers or discharges a resident admission coordinator/designee shall notify the resident/representative of the transfer or discharge and the reason for the move in writing and in the language and manner they understand. Record the reasons for the transfer or discharge in the resident's medical record. Review of the facility policy Notice of Bed Hold and Return last reviewed 3/23/26, indicated the long-term care facility shall provide written information to the resident and his/her family member or legal representative about the bed hold policy before a resident is transferred to the hospital or goes on a therapeutic leave. In the case of an emergency transfer the resident representative/family shall be provided with written notice within 24 hours after the transfer. Review of the clinical record indicated discharged Resident R1 was admitted to facility on 2/12/26. Review of discharged Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/9/26, indicated diagnoses of high blood pressure, Benign Prostatic Hyperplasia (BPH-prostate gland enlargement that can cause urinary difficulty), and muscle wasting and atrophy of multiple cites (loss of muscle tissue). Review of the nursing progress notes dated 2/18/26, indicated discharged Resident R1 was sent to local hospital on 2/16/26, in the am. Resident returned to the facility on 2/26/26. Review of discharged Resident R1's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, on 2/16/26, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility or evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 2/16/26. Review of Nursing progress notes dated 4/15/26, indicated discharged Resident R1 was sent to local hospital. Review of discharged Resident R1's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 4/15/26. Review of the clinical record indicated discharged Resident R2 was admitted to facility on 4/14/26, with the diagnosis of muscle weakness, high blood pressure and hyperlipidemia (high fat in the blood), Review of the nursing progress notes dated 4/22/26, indicated discharged Resident R2 was sent to local hospital. Review of discharged Resident R2's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 4/22/26. Review of the clinical record indicated Resident R3 was admitted to facility on 4/14/26, with the diagnosis of trigeminal neuralgia (causes intense facial pain) and high blood pressure. Review of nursing progress note dated 4/20/26, indicated Resident R3 was transferred to local hospital. Review of discharged Resident R3's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 4/20/26. During an interview completed on 4/25/26, the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for one of three residents (discharged Resident (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1) and failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for three of three resident hospital transfers (discharged Resident R1, discharged Resident R2 and Resident R3). 28 Pa. Code: 201.14.(a) Responsibility of licensee.28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights.