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	05/31/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577 Based on review of facility policies, clinical records, observations, resident and staff interviews, it was determined that the facility failed to determine the ability to self-administer medications for one of six residents (Resident R114). Findings include: A review of the facility's policy Medication Administration dated 4/17/24, indicated that medications shall be administered only upon the order of physicians. No medication shall be left at the resident's bedside. The nurse administering the medication shall stay with the resident until the medication is taken. If a medication has been opened and is refused by a resident, it shall be destroyed. Review of Resident R114's clinical record indicated she was admitted to the facility on [DATE]. Review of Resident R114's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/20/24, indicated diagnosis of hypertension (high blood pressure in the arteries), osteoporosis (condition when the bones become brittle and fragile), and anxiety. Review of Resident R114's physician orders failed to include an order for self-administration of medications. Review of Resident R114's care plan dated 5/15/24, failed to include self-administration of medication management. Review of Resident R114's clinical record failed to include a Self-Administration of Medication assessment. During an observation on 5/28/24, at 10:25 a.m., revealed a medication cup with two oval pills inside sitting on the overbed table. During an interview on 5/28/24, at 10:26 a.m., Resident R114 stated that she is not taking the two pills that were in the medication cup on her overbed table. During an interview on 5/28/24, at 10:33 a.m., the Registered Nurse (RN) Employee E6 confirmed that two pills were at bedside and removed the medications. (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: 395034	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/24, at 3:15 p.m., the Director of Nursing confirmed that the medication was at bedside and the facility failed to determine the ability to self-administer medications for one of six residents (Resident R114). 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services. 28 Pa. Code: 211.9(a)(1) Pharmacy services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395034	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER: Vincentian Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 111 Perrymont Road Pittsburgh, PA 15237	

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on 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 three out of three residents sampled with facility-initiated transfers (Residents R17, R38, and, R93). Findings include: Review of facility policy Transfers Between Facility and Hospital dated 4/17/24, indicated a resident Transfer and Referral record must be completed in full and sent with the resident. The following information shall be included: the reason for the transfer, the resident's physical status, the resident's psychosocial status, a summary of care, treatment, and services the resident has received, the resident's progress towards goals, a list of community resources or referrals made or provided to the patient, and the resident's normal level of ADL prior to the illness requiring transfer to the acute hospital. The complete medical record shall be sent with the resident, including completed nursing notes and medication records. Review of facility policy Transfer/Discharge Documentation dated 4/17/24, indicated when a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider. Should a resident be transferred or discharged for any reason, the following information will be communicated to the receiving facility or provider: the basis for the transfer or discharge, contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, advance directive information, all special instructions or precautions for ongoing care as appropriate, comprehensive care plan goals, and all other necessary information, including a copy of the residents discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care. Review of the clinical record revealed that Resident R17 was admitted to the facility on [DATE]. Review of Resident 17's MDS (Minimum Data Set- periodic assessment of resident care needs) dated 3/22/24, indicated diagnoses of multiple sclerosis (a disease that affects central nervous system), high blood pressure, and weakness. Review of Resident R17's clinical record revealed the resident was transferred to the hospital on 3/9/24 and returned to the facility on [DATE]. Review of Resident R17'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, 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. Review of the clinical record indicated Resident R38 was admitted to the facility on [DATE]. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R38's MDS dated [DATE], indicated diagnoses of muscle weakness, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and volvulus (an obstruction due to twisting or knotting of the bowel). Review of Resident R38's clinical record revealed the resident was transferred to the hospital on 3/28/24 and returned to the facility on [DATE]. Review of Resident R38'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, 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. Review of the clinical record indicated Resident R93 was admitted to the facility on [DATE]. Review of Resident R93's MDS dated [DATE], indicated diagnoses of dementia, muscle weakness, and Parkinson's Disease (neuromuscular disorder causing tremors and difficulty walking). Review of Resident R93's clinical record revealed the resident was transferred to the hospital on 11/26/23 and returned to the facility on [DATE]. Review of Resident R93'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, 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. During an interview on 5/30/24, at 2:03 p.m. the Assistant Director of Nursing (ADON) stated, We don't normally type in the progress notes what we send with the resident to the hospital. During an interview on 5/30/24, at 2:03 p.m. the ADON confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for three out of three residents sampled with facility-initiated transfers (Resident R17, R38, and R93). 28 Pa. Code 201.29 (a)(c.3)(2) Resident rights.

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of resident clinical records, and staff interviews, it was determined that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for three of four residents (Resident R17, R38, and R93). Findings include: Review of Title 42 Code of Federal Regulations S483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged ; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and [NAME] of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. Review of the clinical record revealed that Resident R17 was admitted to the facility on [DATE]. Review of Resident 17's MDS (Minimum Data Set- periodic assessment of resident care needs) dated 3/22/24, indicated diagnoses of multiple sclerosis (a disease that affects central nervous system), high blood pressure, and weakness. Review of Resident R17's clinical record revealed the resident was transferred to the hospital on 3/9/24 and returned to the facility on [DATE]. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R17's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE]. Review of the clinical record indicated Resident R38 was admitted to the facility on [DATE]. Review of Resident R38's MDS dated [DATE], indicated diagnoses of muscle weakness, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and volvulus (an obstruction due to twisting or knotting of the bowel). Review of Resident R38's clinical record revealed the resident was transferred to the hospital on 3/28/24 and returned to the facility on [DATE]. Review of Resident R38's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE]. Review of the clinical record indicated Resident R93 was admitted to the facility on [DATE]. Review of Resident R93's MDS dated [DATE], indicated diagnoses of dementia, muscle weakness, and Parkinson's Disease (neuromuscular disorder causing tremors and difficulty walking). Review of Resident R93's clinical record revealed the resident was transferred to the hospital on 11/26/23 and returned to the facility on [DATE]. Review of Resident R93's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE]. During an interview on 5/30/24, at 2:25 p.m. the Director of Nursing (DON) stated, We don ' t usually send Ombudsman notification when a resident is sent out to the hospital. During an interview on 5/30/24, at 2:25 p.m. the DON confirmed that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for three of four residents (Resident R17, R38, and R93). 28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of facility policies, clinical records and staff interview, it was determined that the facility failed to administer medications as prescribed by the physician for one of five residents (Resident R174), failed to perform weekly skin assessments per physician order for three of ten residents (Resident R50, R382, and R385), and failed to obtain weekly labs for one of six residents (Resident R50). Findings include: Review of facility policy Skin assessment dated [DATE], indicated the facility will assess all resident's skin integrity and identify those at risk for developing pressure ulcers. The nurse will complete a skin assessment upon admission/readmission and weekly times four weeks, minimally. Review of the clinical record revealed that Resident R50 was admitted to the facility on [DATE]. Review of Resident R50's MDS (Minimum Data Set- periodic assessment of resident care needs) dated 4/4/24, indicated diagnoses of anemia (too little iron in the body causing fatigue), dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and heart failure (a progressive heart disease that affects pumping action of the heart muscles). Review of Resident R50's physicians orders, dated 10/11/23, at 12:40 p.m. indicated weekly skin assessments. Document in skin only evaluation assessment. Review of Resident R50's physicians orders, dated 10/6/24, at 12:40 p.m. indicated monitor Basic Metabolic Panel (BMP) labs every week. Review of Resident R50's weekly skin assessments on 5/29/24, at 1:05 p.m. indicated facility failed to complete a weekly skin assessment on 10/25/23, 11/8/23, 11/29/23, 12/13/23, 12/20/23, 1/10/24, 1/17/24, 2/28/24, 3/6/24, 3/13/24, 3/27/24, 4/3/24, 4/10/24, 4/17/24, 4/24/24, 5/8/24, 5/15/24, 5/22/24, and 5/29/24. Review of Resident R50' s clinical record, on 5/30/24, at 1:40 p.m. failed to indicate that weekly lab work was obtained. Review of the clinical record revealed that Resident R174 was admitted to the facility on [DATE]. Review of Resident 174's MDS dated [DATE], indicated diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), respiratory failure (when not enough oxygen passes from the lungs), and muscle weakness. Review of the clinical record indicated that Resident R174 arrived at the facility on 4/18/24 with medication orders from the hospital that included to provide Trelegy Ellipta (fluticasone furoate 100 micrograms (mcg), umeclidinium 62.5 mcg and vilanterol 25 mcg- a medication that is inhaled and used to treat COPD) 1 puff inhalation once a day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record indicated that Resident R174 resided at the facility from 4/18/24 through 4/24/24 and had not received Trelegy Ellipta medication during her stay as per physician order. During an interview on 5/30/24, at 11:03 a.m. Director of Nursing confirmed that the facility failed to administer the medication as ordered. Review of the clinical record indicated Resident R382 was admitted to the facility on [DATE]. Review of Resident R382's MDS dated [DATE], indicated diagnoses of high blood pressure, atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), and heart failure. Review of Resident R382's physicians orders, dated 5/21/24, at 1:30 p.m. indicated weekly skin assessments. Document in skin only evaluation assessment. Review of Resident R382' s weekly skin assessments on 5/29/24, at 1:40 p.m. indicated facility failed to complete a weekly skin assessment on 5/28/24. Review of clinical record indicated Resident R385 was admitted to the facility on [DATE]. Review of Resident R385's MDS dated [DATE], indicated diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), heart failure, and dysphasia (difficult swallowing). Review of Resident R385's physicians orders, dated 5/21/24, at 1:30 p.m. indicated weekly skin assessments. Document in skin only evaluation assessment. Review of Resident R385's weekly skin assessments on 5/29/24, at 1:40 p.m. indicated facility failed to complete a weekly skin assessment on 5/28/24. During an interview on 5/30/24, at 9:30 a.m. the Registered Nurse (RN) Employee E7 stated that nursing must sign the Treatment Administration Record (TAR) and complete a skin only evaluation assessment in order for it to be complete. During an interview on 5/30/24, at 11:40 the Director of Nursing confirmed that the facility failed to perform weekly skin assessments per physician order for three of ten residents (Resident R50, R382, and R385), and failed to obtain weekly labs for one of six residents (Resident R50). 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing Services.

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

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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** 46337 Based on review of facility policy, clinical records, observations and staff interviews it was determined that the facility failed to prevent accidents for one of four residents (Resident R13), and ensure that residents received neurological assessments after an incident involving an unwitnessed fall for two of four residents (Residents R54 and R81). Findings include: The facility Falls and Falls with Major Injury policy dated 4/26/23, last reviewed 4/17/24, indicated it is the facility policy to minimize the risk of falling, and injuries sustained from falls, without compromising the mobility and functional independence of residents. It was indicated after a fall, if a resident has just fallen or is found in the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities, and complete neurological checks for 72 hours. It was indicated neurological checks must be performed 4x for 15 minutes, 4x for 30 minutes, 4x for one hour, 4x for four hours, and 4x for four shifts. Review of Residents R13's admission record indicated she was admitted on [DATE]. Review of Residents R13's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 3/16/24, indicated she had diagnoses that included high blood pressure, muscle weakness, and dementia. Review of Residents R13's care plan dated 3/29/24, indicated she was at risk of falls. Review of Residents R13's clinical nurse note dated 4/4/24, at 10:21 p.m. indicated the resident slid off the bed during care and hit her head against the wall. It was indicated the resident had bruising and swelling noted to the forehead and laceration to the bridge of nose with a moderate amount of blood draining. Review of Resident R13's incident report dated 4/4/24, completed by nurse aide, Employee E5 stated during care the resident was turned on her left side and when NA, Employee E5 grabbed the brief and wipes, the resident started [NAME] and threw her legs over the side of the bed and slowly slid off feet first. It was indicated NA, Employee E5 was unable to pull the resident over to her because her weight pulled her off the bed. It was indicated the resident slid down and hit her head off the wall. Review of Resident R13's Hospital Discharge Summary dated 4/5/24, indicated the resident had a traumatic hematoma (a collection of blood outside of blood vessels, often due to injury or trauma), a head injury, and a nasal laceration. Review of Residents R54's admission record indicated she was admitted on [DATE]. (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 Residents R54's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 2/23/24, indicated she had diagnoses that included osteoporosis (condition that weakens bones and increases the risk of fractures), muscle weakness, and dementia. Review of Residents R54's care plan dated 1/19/24, indicated she was at risk of falls. Interventions indicated to follow post fall protocol as needed. Review of Residents R54's clinical nurse note dated 5/13/24, at 8:14 a.m. indicated at 6:30 a.m. the resident was sitting at the edge of the bed completely dressed. The resident stated she fell and bumped the top of her head and left arm. Review of Resident R54's Neurological Check List-V2 report dated 5/13/24, failed to include documentation of the resident's vital signs every 15 minutes x 4, then every 30 minutes x 4, then hourly x 4, then every four hours x 4, then every shift x 4. Review of the clinical record indicated Resident R81 was admitted to the facility on [DATE]. Review of Resident R81's MDS dated [DATE], indicated diagnoses of muscle weakness, overactive bladder, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of a nursing progress note dated 3/12/24, stated, At 3:30 p.m., resident was found on the floor by Nurse Aide (NA) in the bathroom. As this nurse entered, resident was sitting on the floor in front of the sink on her buttocks with hands by her sides. Resident denies hitting head. Resident was assessed and no obvious injuries were noted. Resident was assisted up and back into her wheelchair with assist of two. Review of Resident R81's Neurological Check List-V2 dated 3/12/24, indicated only 15 neurological checks were completed out of 21 opportunities. During an interview on 5/30/24, at 9:16 a.m. Licensed Practical Nurse, Employee E3 stated when a resident falls, a supervisor must be notified and an assessment must be completed and neurological checks started. It was indicated neurological assessments are completed every 15 minutes x 4, then every 30 minutes x 4, then hourly x 4, then every four hours x 4, then every shift x 4. During an interview on 5/30/24, at 9:20 a.m. Nurse Aide (NA), Employee E4 stated when changing a resident in bed, they must be rolled towards self, and if they are bigger two people must be used. During an interview on 5/30/24, at 9:30 a.m. the Assistant Director of Nursing, confirmed that the facility failed to ensure that a resident's neurological assessments were completed as required (Resident R54), and failed to prevent accidents from occurring for two of four Residents (Resident R13 and R54). During an interview on 5/30/24, at 11:38 a.m. the Director of Nursing DON confirmed that Resident R81's neurological checks were not completed per facility policy. 28 Pa. Code: 201.14(a) Responsibility of licensee. (continued on next page)

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	395034	A. Building B. Wing	05/31/2024

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F 0689 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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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of facility policy, review of clinical records, observations, and staff interviews it was determined that the facility failed to ensure a physician order for a urinary catheter (insertion of a tube into the bladder to remove urine) for one of three residents (Resident R385), and failed to make certain that appropriate treatments and services were provided for the use of a urinary catheter as required for two of three residents (Resident R49, and R385). Findings include: Review of the facility policy Indwelling urinary catheter insertion and Maintenance, dated 4/17/24, indicated that a resident should have a physician's order for a catheter that includes the type of catheter and the purpose for the catheter. Change catheters and drainage bags based on physician order. Review of the clinical record revealed that Resident R49 was admitted to the facility on [DATE]. Review of Resident 49's MDS (Minimum Data Set- periodic assessment of resident care needs) dated 4/30/24, indicated diagnoses of Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking), obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed flow of urine) and muscle weakness. Section H0100 indicated the utilization of an indwelling catheter. During an observation on 5/28/24, at 11:25 a.m. Resident R49 was in bed, with his urinary drainage bag hanging on the bed with no privacy cover. During an interview on 5/28/24, at 11:59 a.m. Registered Nurse Employee E8 confirmed that the facility failed to implement the use of a privacy bag as required for Resident R49. Review of clinical record indicated Resident R385 was admitted to the facility on [DATE]. Review of Resident R385's MDS dated [DATE], indicated diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and dysphasia (difficult swallowing). Review of Resident R385's physicians orders on 5/28/24, at 2:15 p.m. indicated resident to have a foley catheter dignity bag cover on at all times, foley care every shift, and record and measure foley output. Review of Resident R385's physicians orders dated 5/28/24, failed to indicate that Resident R385 had current orders for a foley catheter, size of catheter, when to change the foley catheter or a valid medical diagnosis for the foley catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395034	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER Vincentian Home		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Perrymont Road Pittsburgh, PA 15237	

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/29/24, at 11:40 a.m. Resident R385 was in her bed and did not have a dignity bag covering her foley bag. During an interview on 5/29/24, at 11:45 a.m. Registered Nurse (RN) Employee E7 stated, Residents usually have all those foley orders but I don't see them. During an interview on 5/29/24, at 11:47 a.m. Registered Nurse Employee E7 confirmed that the facility failed to implement the use of a privacy bag as required for Resident R385. During an interview on 5/30/24, at 3:15 p.m. the Director of Nursing confirmed that the facility failed to ensure a physician order for a urinary catheter for one of three residents (Resident R385), and failed to make certain that appropriate treatments and services were provided for the use of a urinary catheter as required for two of three residents (Resident R49, and R385). 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa code: 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to identify and address significant weight loss in a timely manner for one out of five residents (Resident R78), failed to obtain daily weights for two out of five residents (Resident R114 and R382), and failed to notify physician of weight gain per physician orders for one out of five residents (R114). Findings include: Review of facility policy Weighing and Measuring the Resident dated 4/17/24, indicated the threshold for significant unplanned and undesired weight loss/gain will be based on the following criteria: 1 month - 5% weight loss is significant; greater than 5% is severe 3 months - 7.5% weight loss is significant; greater than 7.5% is severe 6 months - 10% weight loss is significant; greater than 10% is severe Review of the clinical record indicated Resident R78 was admitted to the facility on [DATE]. Review of Resident R78's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/6/24, indicated diagnoses of high blood pressure, muscle weakness, and diabetes (too much sugar in the blood). A review of Resident R78's weight record indicated the following weights: 2/1/24: 109.2 pounds 2/20/24: 116 pounds 3/2/24: 116.8 pounds 4/3/24: 105.2 pounds, a loss of 9.9% in one month (from 3/2/24) 5/6/24: 104.6 pounds, a loss of 10.4% in two months (from 3/2/24) During a review of Resident R78's clinical record conducted on 5/31/24, at 9:54 a.m. revealed no documentation from dietary was present to identify the severe weight loss of 9.9% in one month and 10.4% two months. During an interview on 5/31/24, at 10:14 a.m. the Dietary Technician Employee E1 confirmed she was aware of Resident R78's weight loss and is following the resident, however she failed to document the severe weight loss was addressed in the clinical record. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/31/24, at 10:55 a.m. the Nursing Home Administrator confirmed that the facility failed that weight loss was identified and addressed in a timely manner for Resident R78. Review of the clinical record indicated Resident R114 was admitted to the facility on [DATE]. Review of Resident R114's MDS dated [DATE], indicated diagnoses of hypertension (high blood pressure in the arteries), osteoporosis (condition when the bones become brittle and fragile), and anxiety. Review of Resident R114's Mini Nutritional Assessment Screening, dated 5/16/24, at 11:10 a.m. indicated the resident is at risk for malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat). Review of Resident R114's Nutrition Assessment, dated 5/20/24, at 11:15 a.m. indicated the facility will monitor weights, nutritional labs, and intake. Review of Resident R114's physician orders, dated 5/15/24, at 11:20 a.m. indicated to weigh resident daily before breakfast. If there was weight gain of more than three pounds in a day or five pounds in a week to notify physician. Review of Resident R114's physician orders, dated 5/17/24, at 11:20 a.m. indicated the resident is ordered a shake em up supplement every day. Review of Resident R114's careplan, dated 5/20/24, indicated to offer nutritional supplements as ordered, assist with meals as needed and maintain weight without significant weight change. During a review of Resident 114's clinical record on 5/29/24, at 12:30 p.m. indicated that daily weights were missed on 5/23/24 and 5/27/24. During a review of Resident 114's clinical record on 5/29/24, at 12:35 p.m. indicated the resident had a 4.8 pound weight gain between 5/16/24 and 5/17/24 and the facility failed to notify the physician per order. Review of the clinical record indicated Resident R382 was admitted to the facility on [DATE]. Review of Resident R382's MDS dated [DATE], indicated diagnoses of hypertension, atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), and heart failure (a progressive heart disease that affects pumping action of the heart muscles). Review of Resident R382's Mini Nutritional Assessment Screening, dated 5/23/24, at 10:40 a.m. indicated the resident is at risk for malnutrition. Review of Resident R382's Nutrition Assessment, dated 5/28/24, at 10:45 a.m. indicated the facility will monitor weights, nutritional labs, and intake. Review of Resident R382's physician orders, dated 5/22/24, at 10:50 a.m. indicated to weigh resident daily before breakfast. If there was weight gain of more than three pounds in a day or five pounds in a week to notify physician. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R382's careplan, dated 5/28/24, indicated to assist with meals as needed, offer food preferences as able and weigh resident as ordered. During a review of Resident 382's clinical record on 5/29/24, at 12:30 p.m. indicated that a daily weight was missed on 5/23/24. During an interview on 5/29/24, at 12:40 p.m. the Director of Nursing confirmed that the facility failed to obtain daily weights for two out of five residents (Resident R114 and R382), and failed to notify physician of weight gain per physician orders for one out of five residents (R114). 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48546 Based on review of facility policy, observation, and staff interviews, it was determined that the facility failed to properly secure one of four medications carts reviewed (Building One Second Floor Low Side Med Cart). Findings include: Review of facility policy Drug Acquisition, Storage, Inspection, and Dispensing dated 4/17/24, indicated medications shall be stored in a secure manner. Lockable medication carts shall be used to store unit-of-use medications in the resident medication dose system. These carts shall be locked when not attended. During an observation on 5/28/24, at 10:09 a.m. the Building One Second Floor Low Side Med Cart was observed unlocked and unattended with the top drawer pulled open. During an interview on 5/28/24, at 10:10 a.m. Registered Nurse Employee E2 confirmed that the medication cart was unattended, unlocked, and the top drawer was pulled open. During an interview on 5/28/24, at 1:31 p.m. the Nursing Home Administrator confirmed that the facility failed to properly secure one of four medications carts reviewed (Building One Second Floor Low Side Med Cart). 28 Pa. Code: 211.9(a)(1)(h)(k)(l)(1) Pharmacy services. 28 Pa. Code:211.12(d)(1)(2)(3)(5) Nursing services.

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on a review of facility policy, resident clinical records, and staff interview, it was determined the facility failed to obtain a diagnosis for hospice services and to ensure the coordination of hospice services with facility services to meet the needs of each resident for end of life care for three of three residents (Resident R17, R53, R62). Findings include: Review of the facility policy Hospice Services dated 4/17/24, indicated that care for the dying resident shall be a collaborative effort between the staff of the designated hospice provider and the staff of the long term care facility. The facility will obtain information from hospice that includes names and contact information for hospice staff involved in the resident's care, and how to access the hospice's 24 hour on-call system. Review of the clinical record revealed that Resident R17 was admitted to the facility on [DATE]. Review of Resident 17's MDS (Minimum Data Set- periodic assessment of resident care needs) dated 3/22/24, indicated diagnoses of multiple sclerosis (a disease that affects central nervous system), high blood pressure, and weakness. Section O - Special Treatments, Procedures, and Programs indicated hospice care while a resident. Review of Resident R17's clinical record revealed a physician order dated 3/11/24, to admit to hospice, but did not include a diagnosis related to the need of hospice services. Review of Resident R17's current comprehensive care plan failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to included contact information for the hospice agency and how to access the hospice's 24 hour on-call system. Review of the clinical record indicated Resident R53 was admitted to the facility on [DATE]. Review of Resident R53's MDS dated [DATE], indicated diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), depression (a constant feeling of sadness and loss of interest), and age-related physical debility. Section O - Special Treatments, Procedures, and Programs indicated hospice care while a resident. Review of Resident R53's clinical record revealed a physician order dated 1/26/24, to admit to hospice services, but did not include a diagnosis related to the need of hospice services. Review of Resident R53's comprehensive care plan failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to include contact information for the hospice agency and how to access the hospice's 24 hour on-call system. Review of the clinical record revealed that Resident R62 was admitted to the facility on [DATE]. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 62's MDS dated [DATE], indicated diagnoses of cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain), schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior), and abnormal posture. Review of Resident R62's clinical record revealed a physician order dated 2/28/24, to admit to hospice, but did not include a diagnosis related to the need of hospice services. Review of Resident R62's current comprehensive care plan failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to included contact information for the hospice agency and how to access the hospice's 24 hour on-call system. During an interview on 5/30/24, at 11:37 a.m. Director of Nursing confirmed that the facility failed to obtain a diagnosis for hospice services and to ensure the coordination of hospice services with facility services to meet the needs of each resident for end of life care for three of three hospice residents (R17, R53, and R62). 28 Pa. Code 211.2(a) Physician services 28 Pa. Code 211.11(d) Resident care plan