

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 05/02/2025
NAME OF PROVIDER OR SUPPLIER Vincentian Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469</p> <p>Based on review of facility policy, observations and staff interview, it was determined that that the facility failed to determine it was safe to self-administer medications, did not have a current order or care plan to self-administer medications, or an interdisciplinary assessment for one of five residents (Resident R302).</p> <p>Findings include:</p> <p>Review of the facility policy Self-Administration of Medications by Residents last reviewed 3/19/25, indicated self-administration of medication is the ability of a resident to take medications independently without assistance from another person. The resident shall be assessed for competency using the assessment for self-administration of medications. The results shall be documented in the resident's record and care plan. Specific orders for self-administration of medication shall be documented in the resident's medical record and care plan. Each resident's medication shall be clearly labeled by the prescribing pharmacy.</p> <p>Review of the facility policy Skin and Wound Assessment last reviewed 3/19/25, indicated residents identified with a pressure ulcer or non-pressure related skin conditions will be monitored for evidence of further breakdown or complication. Verify a physician's order for the procedure.</p> <p>Review of the facility policy Medications Administration last reviewed 3/19/25, indicated medications shall be administered only upon the order of physicians and physician extenders who are authorized and have been granted clinical privileges to write such orders. Licensed nurses shall administer prescribed medications, fluids and treatments.</p> <p>Review of the admission record indicated Resident R302 was admitted to the facility on [DATE], with diagnosis that included irritable bowel syndrome (IBS- a gastro-intestinal disorder that causes abdominal pain, bloating and changes in bowel patterns), overactive bladder (sudden urges to urinate that are hard to control), and dysphagia (difficulty in swallowing).</p> <p>During an interview and observation completed on 4/28/25, at 10:51 a.m. Resident R302 voiced that she has frequent episodes of incontinence and her bottom was raw, bleeding and sore. Resident 302 stated I wash and clean myself and apply Aquaphor ointment and desitin cream, and further stated I would like a good look over when I get my shower. The Aquaphor ointment was observed sitting next to the commode in her bathroom.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395034
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview completed on 4/28/25, at 10:58 a.m. Registered Nurse (RN) Employee E1 confirmed the Aquaphor ointment was in Resident R302's bathroom and stated, there is not a label, I think her family brought it in for her to use.</p> <p>Review of Resident R302's clinical record on 4/28/25, at 11:00 a.m. failed to include orders for the Aquaphor ointment or for self-administration of medications, failed to include a care plan, or an interdisciplinary assessment.</p> <p>During an interview completed on 4/30/25, at 2:43 p.m., the Director of Nursing confirmed Resident R1 did not have a current order, care plan to self-administer medications, or an interdisciplinary assessment, and that the facility failed to determine it was safe to self-administer medications for one of five residents (Resident R1).</p> <p>28 Pa. Code 201. 18(b)(1) Management</p> <p>28 Pa code:211.10(c)(d) Resident care policies</p> <p>28 Pa Code:211.12(c)(d)(1)(2)(5) Nursing services</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469</p> <p>Based on facility policy, clinical record review, and interview, it was determined that the facility failed to have physician order specifications relating to the size of indwelling catheter (a thin, flexible tube inserted into the bladder through the urethra to drain urine) and balloon inflation amount (secures catheter to bladder) for one of three residents (Resident R305).</p> <p>Findings include:</p> <p>Review of the facility policy Foley Catheter Care last reviewed 3/19/25, indicates to maintain a closed, sterile drainage system and minimize the risk of infection. Obtain physician order for foley catheter use. Include bulb and catheter size, frequency of catheter changes and catheter care instructions.</p> <p>Review of Admission record indicated Resident R305 was admitted to the facility on [DATE], with the diagnosis of dysphagia (difficulty in swallowing), chronic kidney disease (affects the kidneys ability to filter waste), and urinary retention (bladder doesn't completely empty).</p> <p>Review of Resident R305's physician orders dated 4/22/25, indicated exchange Foley catheter on the 22nd of each month and when directed by provider.</p> <p>Review of Resident R305's physician orders dated 4/22/25, indicated Foley catheter bag dignity cover on at all times.</p> <p>Review of Resident R305's physician orders dated 4/22/25, indicated irrigate Foley catheter with 50 milliliters (mL) Normal Saline Solution (NSS) if complete or partial occlusion suspected. May irrigate once each shift. Notify provider if irrigation ineffective. Exchange Foley if directed by provider as needed</p> <p>Review of Resident R305's physician orders on 4/4/25, failed to include specifications for size and balloon inflation amount for the indwelling foley catheter.</p> <p>Interview on 4/30/25, at 3:02 p.m. the Assistant Director of Nursing (ADON) Employee E7 confirmed Resident R305's clinical record failed to provide specifications for size and balloon inflation amount of the indwelling catheter and that the facility failed to have physician order specifications relating to size of an indwelling catheter and balloon inflation amount for one of three residents (Resident R305).</p> <p>28 Pa. Code 201. 18(b)(1) Management.</p> <p>28 Pa code:211.10(c)(d) Resident care policies.</p> <p>28 Pa Code:211.12(c)(d)(1)(2)(5) Nursing services.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469</p> <p>Based on review of facility policies, observations, clinical record review, and staff, resident, and family interviews, it was determined that the facility failed to provide appropriate respiratory care for two of five residents (Residents R67 and R307).</p> <p>Findings include:</p> <p>Review of the facility policy C-PAP/Bi-PAP Storage dated 3/19/25, indicated it is the policy of the facility to store CPAP (a method of positive pressure ventilation used with patients who are breathing spontaneously) machine in a clean dry environment. When not in use, place clean mask in a plastic bag (not airtight).</p> <p>Review of the facility policy Oxygen Concentrators-Usage and Care last reviewed 3/19/25, indicates Nasal cannulas, masks, tubing and water bottles are to be changed weekly. The water bottle and tubing are to be dated and stored in a plastic bag attached to the concentrator when not in use.</p> <p>Review of the clinical record indicated that Resident R67 was admitted to the facility on [DATE], with diagnoses of anemia (a condition that develops when your blood produces a lower-than-normal amount of healthy red blood cells), heart failure (condition where the heart muscle doesn't pump blood as well as it should), and dysphagia (difficulty swallowing).</p> <p>Review of Resident R67's physician order dated 4/4/25, indicated to apply CPAP on at bedtime. Reconnect mask and tubing (mask, reservoir, and tubing cleaned every morning and allowed to air dry). Utilize pre-programmed adaptive settings calibrated by pulmonology. Fill humidification reservoir with distilled water to level indicated. The order failed to include the settings for the CPAP and a diagnosis.</p> <p>Review of Resident R67's unsigned and undated baseline care plan failed to include care interventions related to the resident's CPAP.</p> <p>Review of Resident R67's MDS dated [DATE], indicated the diagnoses were current.</p> <p>Review of Resident R67's care plan dated 4/18/25, indicated to provide CPAP maintenance per protocol.</p> <p>During an observation and interview on 4/28/25, at 10:31 a.m. Resident R67's CPAP mask was observed not in a bag, sitting on the bed. Resident R67 stated I use my CPAP every night.</p> <p>During an observation on 4/29/25, at 10:05 a.m. Resident R67's CPAP mask was sitting on the resident's dresser not stored in a bag.</p> <p>During an observation on 4/30/25, at 9:40 a.m. Resident R67's CPAP mask was sitting on the resident's dresser not stored in a bag.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/30/25, at 9:58 a.m. Registered Nurse, Employee E3 confirmed Resident R67's CPAP mask was not stored properly.</p> <p>During an interview on 4/30/25, at 11:03 a.m. the Director of Nursing (DON) confirmed the facility failed to implement a baseline care plan for Resident R67's CPAP.</p> <p>Review of the admission record indicated Resident R307 was admitted to the facility on [DATE], with the diagnosis of pneumonia (infection in the lungs), congestive heart failure (CHF- heart can ' t pump blood as well as it should) and emphysema (chronic lung disease that causes shortness of breath and damage to the lung).</p> <p>During an observation completed on 4/28/25, at 10:34 a.m. Resident R307 was in bed with his oxygen on via nasal canula (flexible tubing used to deliver oxygen) the tubing failed to be labeled with a date.</p> <p>During an interview completed on 4/28/25, at 10:36 a.m. LPN Employee E2 confirmed the tubing failed to be labeled with a date.</p> <p>During an interview on 5/2/25, at 11:56 a.m. the Nursing Home Administrator (NHA) and DON confirmed the facility failed to provide appropriate respiratory care for two of five residents (Residents R67 and R307).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.12(d)(1)(2)(5) Nursing services</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</p> <p>Based on review of facility policy, clinical records, and staff interviews it was determined that the facility failed to implement pharmaceutical services to ensure accurate provision of medications for one of five residents (Resident R250).</p> <p>Findings include:</p> <p>Review of the facility policy, Pharmacy Requirements last reviewed 3/19/25, indicated regular and reliable pharmaceutical service is available to provide residents with prescriptions and non-prescriptions medications, services, and related equipment and supplies. Pharmacy services will be provided routine and timely.</p> <p>Review of Residents R250's admission record indicated admission to the facility on [DATE], with diagnoses of anemia (a condition that develops when your blood produces a lower-than-normal amount of healthy red blood cells), calculus of kidney, and Alzheimer's Disease (a progressive brain disorder that gradually destroys memory, thinking skills, and the ability to carry out daily tasks).</p> <p>Review of Resident R250's physician order dated 4/24/25, indicated to administer two tablets of TheraLith XR (medication formulated to support and maintain normal urine chemistry), two times a day, related to calculus of kidney.</p> <p>Review of Resident R250's April 2025 Medication Administration Record revealed the resident did not receive TheraLith as ordered from 4/24/25, through 4/28/25. A total of nine dose were missed.</p> <p>Review of Resident R250's progress note dated 4/28/25, revealed the resident's TheraLith was unavailable from the pharmacy.</p> <p>During an observation of a medication pass, on 4/29/25, at 10:16 a.m. Resident R250's Theralith was unavailable. Registered Nurse, Employee E10 confirmed Resident R250's TheraLith was not in stock and available for administration.</p> <p>During an interview completed on 4/29/25, at 11:15 a.m. the Nursing Home Administrator (NHA) confirmed the facility failed to implement pharmaceutical services to ensure accurate provision of medications for one of four residents (Resident R250).</p> <p>During an interview on 4/29/25, at 2:51 p.m. the Director of Nursing (DON) stated the pharmacy was out of stock of TheraLith and that was the reason resident did not receive the medication as ordered.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code 211.9 (a)(1)(k)(l)(1)(2)(3)Pharmacy services</p> <p>28 Pa. Code 211.10 (c) Resident care policies.</p> <p>(continued on next page)</p>		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12 (d)(1)(5) Nursing services.

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>49469</p> <p>Based on review of facility policies, observations and staff interview it was determined that the facility failed to store all drugs and biologicals in a safe, secure, and orderly manner for one of four nursing units (Building 2-2) failed to properly store medical supplies in two of five medication carts (County high hall and Country low hall) and two of four medication rooms (Beach hall high and Country hall high).</p> <p>Findings include:</p> <p>Review of the facility policy Medication Storage last reviewed 3/19/25, indicated medications and biologicals are stored safely, securely, and properly following manufactures recommendations or those of the supplier. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications are allowed access to medications. Medication rooms, carts, and medications supplies are locked or attended by persons with authorized access.</p> <p>Review of the facility policy Medication Administration last reviewed 3/19/25, indicated the individual administering a medication shall be aware of the following information including but not inclusive to the expiration date has not been exceeded.</p> <p>During an observation and interview on 4/28/25, at 10:07 a.m., Resident R254 was observed to have the following medications located on the bedside table in a tissue box.</p> <ul style="list-style-type: none"> -(1) Bottle of Systane Complete PF eye drops -(1) Bottle of Refresh Digital PF eye drops -(1) Ventolin HFA Inhaler 90 mcg per actuation <p>During an interview on 4/30/25, at 9:35 a.m. the above medications were observed again on Resident R254's bedside table in a tissue box.</p> <p>During an interview on 4/30/25, at 9:38 a.m. RN, Employee E3 confirmed Resident R254's medications were not properly stored.</p> <p>During an interview on 4/30/25, at 10:10 a.m. the Nursing Home Administrator confirmed the facility failed to store all drugs and biologicals in a safe, secure, and orderly manner for one of four nursing units (Building 2-2).</p> <p>During a medication cart review on 04/29/25, at 9:18 a.m. the following was observed in the fourth drawer of the Country high hall cart:</p> <ul style="list-style-type: none"> . Two bags of suppositories comingling with oral medications. <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview completed on 4/29/25, at 9:58 a.m. Registered Nurse (RN) Employee E8 confirmed the two bags of suppositories were comingling with oral medications.</p> <p>During a medication cart review on 4/29/25, at 9:35 a.m. the following was observed in the top drawer of the Country high hall cart:</p> <ul style="list-style-type: none"> . 1 vial of COVID 19 testing solution that failed to be labeled with an open date. <p>During an interview completed on 4/29/25, at 9:50 a.m. Licensed Practical Nurse (LPN) Employee E2 confirmed the COVID 19 testing solution failed to be labeled with a date.</p> <p>During a medication storage room observation on 4/29/25, at 9:51 a.m. the following was observed in the Country high hall medication storage refrigerator:</p> <ul style="list-style-type: none"> . Two unlabeled cold brick ice packs <p>During an interview completed on 4/29/25 at 9:56 a.m., LPN Employee E2 confirmed the Country high hall medication storage refrigerator contained unlabeled cold brick ice packs.</p> <p>During a medication storage room observation on 4/30/25, at 9:30 a.m. the following was observed in the Beach high hall cupboard above sink:</p> <ul style="list-style-type: none"> . One box monojet 1 milliliter (ml) insulin safety syringe with the use by date 10/31/24. <p>During an interview completed on 4/30/25, at 9:35 a.m. LPN Employee E9 confirmed that the box of monojet 1 milliliter (ml) insulin safety syringe had a use by date of 10/31/24.</p> <p>28 Pa Code: 211.9 (a) (1) Pharmacy services.</p> <p>28 Pa code: 211.12 (d) (1) (5) Nursing services.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469</p> <p>Based on review of facility policy, observations, and staff interviews, it was determined that that the facility failed to implement a surveillance plan for tracking, and monitoring residents who tested negative for COVID during an outbreak for six of six months (August 2024 to February 2025) and failed to implement infection control practices to prevent cross contamination during a dressing change for one of three residents (Resident R67)</p> <p>Review of the Respiratory Virus Outbreak Toolkit dated 11/14/24, indicated a case-line listing is designed to collect information about all ill cases (residents and staff) during an outbreak in a long-term care facility. It was indicated upon identification of an outbreak, use this template to collect and organize information on cases. The type of test ordered and if pathogens were detected must be recorded.</p> <p>A review of the facility policy Skin and Wound Assessment, last reviewed 3/19/25, guidelines for the application of dry, clean dressings indicates step in procedures include but not inclusive to:</p> <ul style="list-style-type: none"> . Wash and dry your hands thoroughly. Put on clean gloves. . Clean the bedside stand. Establish a clean field. . Place the clean equipment on the barrier. Arrange the supplies so they can be easily reached. . Use a waste basket away from clean field. . Remove the soiled dressing, pull glove over dressing and discard into waste basket. . Wash and dry your hands thoroughly. Put on clean gloves . Cleanse the wound with ordered cleanser. . Remove your gloves, wash your hands, and apply new gloves. . Apply the ordered dressing . Discard disposable items including the barrier. . Clean the bedside stand . Remove the garbage from the waste basket. . Wash and dry your hands thoroughly. <p>A review of the facility procedure Hand Hygiene last reviewed 3/19/25, indicates:</p> <ul style="list-style-type: none"> . Always follow standard precautions. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>. Gloves shall be worn when contact with blood, bodily fluids, mucous membranes, non-intact skin etc., is anticipated.</p> <p>. Change gloves when moving from a contaminated body site to a clean body site on the same resident.</p> <p>Review of the facility's line listing for covid on 4/29/25, at 12:40 p.m. revealed the most recent COVID outbreak started on 8/27/24, and the last positive was on 3/1/25. A further review failed to include residents who tested negative.</p> <p>During an interview on 4/29/25, at 12:55 p.m. the Infection Preventionist (IP), Employee E7 stated I thought the new guidance was not to track residents who tested negative. IP, Employee E7 confirmed the facility failed to ensure residents who tested negative for COVID were included on the facility's line listing.</p> <p>During an interview on 4/29/25, at 3:00 p.m. the Director of Nursing (DON) and IP, Employee E7 confirmed the facility failed to implement a surveillance plan for tracking, and monitoring residents who tested negative for COVID during an outbreak for six of six months (August 2024 to March 2025).</p> <p>Review of the admission record indicated Resident R67 was admitted to the facility on [DATE].</p> <p>Review of R67's Minimum Data Set (MDS-periodic assessment of care needs) dated 4/10/25, included diagnoses of anemia (the blood doesn't have enough healthy red blood cells), hypertension (high blood pressure), and heart failure (the heart doesn't pump blood as well as it should).</p> <p>Review of Resident R67's physician order dated 4/9/25, indicates cleanse right heel with soap and water and pat dry. Apply Medi honey to wound base and cover with calcium alginate hold in place with border gauze daily and as needed</p> <p>During a wound care observation on 4/30/25, at 10:57 a.m. Registered Nurse (RN) Employee E3 washed her hands, put gloves on, placed a basin that contain soapy water and wash cloth on the bed as well as dressing supplies and extra gloves. RN Employee E3 used her inner legs to hold Resident R67's right foot off the floor and removed her sock. RN Employee E3 removed soiled dressing, pulled glove over soiled dressing and placed on the bed, cleansed the wound with a washcloth removed from the basin applied Medi honey onto alginate and placed on heel and covered with border gauze. RN Employee E3 removed her gloves, placed sock back on foot. Picked up the basin containing the washcloth, removed washcloth with her hand and squeezed out the soapy water. Removed remaining items on bed, removed gown and placed into trash in the resident's bathroom and exited the room.</p> <p>During an interview completed on 4/30/25, at 11:16 a.m. RN Employee E3 confirmed a clean field was not established. Pulling the glove over soiled dressing and placing onto the bed, not completing hand hygiene during the dressing change, squeezing out washcloth without gloves and not completing hand hygiene after completion of procedure and that the facility failed to implement infection control practices to prevent cross contamination during a dressing change for one of three residents (Resident R67)</p> <p>(continued on next page)</p>		

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 05/02/2025
NAME OF PROVIDER OR SUPPLIER Vincetian Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12 (d)(3) Nursing Services.