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 03/31/2026
NAME OF PROVIDER OR SUPPLIER Friendship Village of South HI		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to immediately report and investigate a resident's allegation, in response to allegations of abuse, neglect, exploitation, or mistreatment for one of eight residents (Resident R1). This was identified as past non-compliance. Findings include: Review of facility policy RISKWATCH (ABILITY) Incident/Accident Occurrence Reporting System reviewed 1/29/26, indicated the incident types listed included (alleged abuse, includes allegations of team member to resident abuse or complaints of rough handling, equipment related incidents involving a resident, and injury of unknown origin) must be entered completely and accurately, whether they involve a resident or visitor, vendor or any other guest in the community. The licensed nurse, if a nurse responds, or if not the first responder is responsible for entering all reports prior to the end of shift and close to the time of the incident as possible. For our licensed health entities, documentation occurs on the 24- hour report and, as per change of condition standards, the resident is placed on alert monitoring and documentation. Review of the clinical records, resident was admitted to the facility on [DATE] and discharged on 3/11/26. Review of Resident R1's Minimum Data Set (MDS- a periodic assessment of care needs) dated 2/25/26, indicated the diagnoses of, diagnosis traumatic subdural hematoma (collection of blood in the brain due to head trauma), displaced fracture of seventh cervical vertebra (break of a bone in the neck), and traumatic brain injury (damage to the brain from an external force injury, affecting how the brain works). During a clinical record review, a progress note from Registered Nurse (RN) Employee E1 dated 3/7/26 at 11:19 a.m., indicated Resident R1 reported last night during care when he was being boosted in bed his head hit the headboard and is now c/o (complaint of) increased numbness and tingling to LFA (left forearm), 1st and 2nd finger. Positive sensation throughout with pins and needles to LUE (left upper extremity), R (right) hand and bilateral feet. No obvious injury to head or c/o increased pain. CTO (cervical-thoracic orthosis brace intact, missing foam piece underneath bottom portion. Review of Resident R1s plan of care for indicated resident has potential/actual impairment cervical collar and impaired mobility use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. During an interview on 3/31/26, at 12:46 p.m. the Nursing Home Administrator confirmed the resident, and family reported the event to the nursing staff on 3/7/26 without staff making a report. A report and investigation was conducted per facility policy and in accordance with state law on 3/16/26 after the family had emailed administration at the facility with concerns related to the 3/7/26 event. On 3/17/26, the facility initiated a plan of correction that included:Staff in-service education related to reporting alleged abuse, neglect, injury of unknown origin and other reportable events completed on 3/30/26.Audits initiated on 3/18/26 for daily documentation of incidents and accidents completed through 3/31 and will continue. During interviews with three direct care staff on 3/31/26, it was confirmed that all staff interviewed had received staff in-service education on reporting alleged abuse, neglect, injury of unknown origin and other reportable events. During an interview on 3/31/26, at 2:20 p.m., the Nursing Home Administrator and Director of Nursing confirmed that the facility failed (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to immediately report and investigate a resident's allegation, in response to allegations of abuse, neglect, exploitation, or mistreatment. This was identified as past non-compliance. 28 Pa Code: 201.14 (a)(c) Responsibility of licensee. 28 Pa Code: 201.18 (e)(1)(2) Management. 28 Pa Code: 201.29 (a)(c) Resident Rights. 28 Pa Code: 211.12 (a)(c)(d)(1) Nursing services.