

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	
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 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	<p>Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency.</p> <p>Based on observations and a staff interview, it was determined the facility failed to post information for Adult Protective Services (APS) as required in the building. Findings include: The facility must post, in a form and manner accessible and understandable to residents, resident representatives; a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit. Observations conducted on 9/30/25, at approximately 10:30 a.m., in the building, revealed the facility did not have any elements of the State Agency or APS contact information (agency name, address, email, and phone number) as required, posted or accessible to residents or resident representatives. During rounds and an interview, on 10/1/25, at approximately 8:30 a.m., with the Nursing Home Administrator (NHA), the (NHA) confirmed the facility failed to post information for Adult Protective Services (APS), as required in the building. 28 Pa. Code: 201.14(a)Responsibility of licensee. 28 Pa. Code: 201.18(e) Management.</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
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<p>F 0579</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Provide information about how to apply for and use Medicare and Medicaid benefits.</p> <p>Based on observations and a staff interview, it was determined that the facility failed to display (for residents and/or their responsible person) written information on how to apply for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid as required, in the building. Findings include: The facility must display written information in the facility, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. During observations completed on 9/30/25, at approximately 10:30 a.m. in the building, it was revealed that the facility failed to include information on how to apply for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid. During rounds and an interview, on 10/1/25, at approximately 8:30 a.m., with the Nursing Home Administrator (NHA), the (NHA) confirmed the facility failed to display (for residents and/or their responsible person) written information on applying for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid as required, in the building. 28 Pa. Code: 201.14(a)Responsibility of licensee. 28 Pa. Code: 201.18(e) Management.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on review of facility policy, observations, and resident and staff interviews, it was determined that the facility failed to make accessible grievance boxes to residents on three of three locations, nursing units (Dogwood, Pinewood, and Specialty Care). Findings include: A review of the facility policy Resident and Family Grievances reviewed 8/13/25, support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. The Centers for Medicare & Medicaid Services (CMS) does not specify exact height requirements for grievance boxes in skilled nursing facilities. However, CMS mandates that grievance procedures be accessible to all residents, including those with disabilities, in compliance with the Americans with Disabilities Act (ADA). In Pennsylvania, the Department of Health incorporates by reference the federal requirements outlined in 42 CFR Part 483, Subpart B, which pertain to long-term care facilities. These regulations emphasize the importance of accessibility but do not provide additional specifications regarding grievance box placement. To ensure accessibility, the ADA Standards for Accessible Design recommend that operable parts, such as slots on grievance boxes, be mounted between 15 and 48 inches above the floor. This range accommodates individuals using wheelchairs and ensures usability for a broad range of residents. During an observation on 9/30/25, at 10:30 a.m., the grievance boxes were not accessible on nursing units (Dogwood, Pinewood, and Specialty Care). The grievance boxes had been mounted at approximately 55 inches (Dogwood), 61 inches (Pinewood), and 60 inches (Specialty Care) above the floor, out of the reach of residents in wheelchairs. The Specialty Care unit had an armchair blocking access to the grievance box. During rounds on 10/1/25, at 8:30 a.m. the Nursing Home Administrator and surveyor measured the height of the grievance boxes on nursing units (Dogwood, Pinewood, and Specialty Care) and confirmed the grievance boxes had been mounted at approximately 55 inches (Dogwood), 61 inches (Pinewood), and 60 inches (Specialty Care) above the floor, out of the reach of residents in wheelchairs. The Specialty Care unit had an armchair blocking access to the grievance box. During an interview on 10/1/25, at 8:40 a.m. the Nursing Home Administrator confirmed the facility failed to make grievance boxes accessible to residents in three of three locations, nursing units (Dogwood, Pinewood, and Specialty Care). 28 PA Code: 201.18(e)(4) Management. 28 PA Code: 201.29(a)(b)(c) Resident rights.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, documents clinical record and staff interviews, it was determined that the facility failed to make certain a resident was free from the use of physical restraints without a physical restraint order for one of eight residents reviewed (Resident R7). Finding include: Review of facility policy, Resident Rights, reviewed 8/13/25, indicated the resident should be free from mental and physical abuse, and free from chemical and physical restraints, except in emergencies or as authorized in writing by his/her physician. This authorization will be for a specific and limited period of time or whenever necessary to protect the resident from injury to him/herself or to others. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2023, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:-13-15: cognitively intact-8-12: moderately impaired-0-7: Severe impairment Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Minimum Data Set (MDS-federally mandated assessment of a resident's abilities and care needs) dated 9/10/25, included diagnoses of Alzheimer's (progressive disease that destroys memory and other important mental functions), high blood pressure and radiculopathy of lumbar region (compression or irritation of a nerve in the lower back causing pain, numbness, or weakness in the leg, hip or buttocks). Review of Section C: Cognitive Patterns, Question C0500 BIMS Summary Score revealed Resident R7 's score to be 3. Review of Resident R7's orders revealed no order placed for bed to be placed against wall. Review of Resident R7's plan of care revealed no documentation for medical reason or goal of bed being placed against wall. Review of Resident R7's progress notes revealed no documentation of reason/explanation for bed to be placed against the wall. During an interview with the Assistant Director of Nursing (ADON) on 10/1/25, at 1:55 p.m. it was confirmed that the facility failed to make certain a resident was free from the use of physical restraint without a physician's order for one of eight residents reviewed. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.29(a)(c)(d) Resident rights.</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy, and staff interview, it was determined that the facility failed to ensure that resident's medication regime was free from unnecessary psychotropic (substances that act on the brain to alter cognition, perception, and mood) medication for one of eight residents (Resident R7). Finding include: Review of the facility policy Use of Psychotropic Medication, dated 8/13/25, indicated that residents receive psychotropic medication when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or team members convenience, which would deem it a chemical restraint. Adequate indications for use refers to identified, documented clinical rationale for administering medication that is based on assessment of the resident's condition and therapeutic goals after any other treatments have been deemed clinically contraindicated. For psychotropic medications, without documentation in the record explaining that the practitioner has determined that other treatments have been deemed clinically contraindicated the indication for use is inadequate. Adverse consequence refers to unwanted, unintended, or dangerous effects that a drug may have, such as impairment or decline in an individuals' s mental or physical condition or functional or psychosocial status. Psychotropic medications are not prescribed or given on a PRN (as needed) basis unless medication is necessary. PRN orders for psychotropic medications are limited to 14 days. Review of the clinical record indicated Resident R7 was admitted on [DATE], and readmitted on [DATE]. Review of Resident R7's Minimum Data Set (MDS-a periodic assessment of care needs) dated 9/10/25, indicated diagnoses of Alzheimer's (a progressive disease that destroys memory and other important mental functions), high blood pressure and radiculopathy of lumbar region (compression or irritation of nerves in the lower back causing pain, numbness, or weakness to leg, hip or buttocks). Review of Resident R7's physician order dated 7/20/25 through 9/2/25, indicated to administer Seroquel (Quetiapine-a psychotropic medication that can be used to treat various mental and mood conditions, including schizophrenia, bipolar disorder, and major depressive disorder), 12.5mg every twelve hours PRN (as necessary) for agitation in the order summary exceeding the 14 day order. On 8/22/25, order was written for Seroquel 12.5mg to give every day at bedtime for depression and Seroquel 12.5mg every 12 hours PRN for agitation related to depression. On 9/15/25, Seroquel was reordered 12.5mg PRN for agitation due to family request for medication, there is no documented behaviors identified in the progress notes during this time frame. During an interview on 10/1/25, at approximately 2:00 p.m. the Assistant Director of Nursing confirmed that the facility failed to ensure that the residents medication regime was free from unnecessary psychotropic medication for one of eight residents (Resident R7). 28 Pa. Code 211.2(d)(3) Medical Director 28 Pa. Code 211.10(a) Resident care policies.</p>		

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<p>F 0657</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to revise/update care plans for two of eighteen residents to accurately reflect the current status of the resident (Resident R7 and R32). Finding include:Review of the facility policy Care Plans, Comprehensive Person-Centered dated 8/13/25, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.Review of the clinical record indicated Resident R7 was admitted on [DATE], and readmitted on [DATE].Review of Resident R7s Minimum Data Set (MDS-a periodic assessment of care needs) dated 9/10/25, indicated diagnoses of Alzheimer's (a progressive disease that destroys memory and other important mental functions), high blood pressure and radiculopathy of lumbar region (compressed or irritated nerves in lower back causing pain, numbness or weakness in the leg, hip or buttock).Review of Resident R7's order summary revealed no order was placed for bed to be up against the wall.Review of Resident R7's plan of care failed to include goals and interventions related to Resident R7 having their bed placed against the wall creating a physical restraint on one side.Review of the clinical record indicated Resident R32 was admitted to the facility on [DATE]. Review of Resident R32's MDS dated [DATE], indicated diagnoses of non-Alzheimer's dementia, high blood pressure, and depression. Review of resident R32's care plan with a revision date of 1/9/2025, revealed the resident is totally dependent on staff for oral care. Review of Resident R32's progress notes from the Registered Nurse dated 2/15/25 and 2/16/25, indicate oral care not performed resident is independent. Review of Resident R32's Survey Report V2 Personal Hygiene combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers) for the months of July through August of 2025 revealed no documentation of service performed and assistance level required on the following dates: July 2, 3, 4, 6, 7, 8, 11, 13, 17, 19, 20, 21, 22, 23, 25, and 27th August 3, 6, 15, 19, 25, and 26th September 3, 8, 9, 10, 18, 19, 20, and 25thDuring an interview on 9/29/25, at approximately 2:00 p.m. Resident R34's family stated resident is unable to do her own oral care and it doesn't seem like Resident R34 has mouth care done daily or routinely. Resident 34 confirmed she doesn't get oral care daily.During an interview on 10/1/25, at approximately 2:00 p.m. the Director of Nursing and Nursing Home Administrator confirmed the facility failed to revise/update care plans for two of eighteen residents.28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.28 Pa. Code 211.11(e) Resident Care Plan.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, documents, clinical record review, resident, and staff interviews, it was determined that the facility failed to make certain that necessary care and services were provided for thirteen of twenty-four residents (Resident R1, R6, R34, R50, R60, R123, R500, R501, R502, R503, R505, R506, and R507).</p> <p>Findings include:</p> <p>Review of facility policy Activities of Daily Living (ADL), Supporting reviewed 8/13/25, indicated resident will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.</p> <p>The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated that a BIMS (Brief Interview of Mental Status) is a brief screener that aids in detecting cognitive impairment. Scores from a BIMS assessment suggests the following distributions:</p> <p>13 - 15: cognitively intact</p> <p>8 - 12: moderately impaired</p> <p>0 - 7: severe impairment</p> <p>During a group interview, on 9/29/25 at approximately 1:30 p.m., when asked, Do you get the help and care you need without waiting a long time? Does staff respond to your call light timely? consensus from the group was no. Residents (R500, R501, R502, R503, R505, R506, and R507) verbalized frustration with the wait times, residents stated, some staff are quick to respond and some just don't seem to try very hard. Residents reported they experienced wait times of 40 minutes to more than an hour.</p> <p>Review of resident council minutes revealed on 1/8/25 and 8/14/25 residents expressed concerns over long wait times for assistance.</p> <p>Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE].</p> <p>Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/30/25, indicated diagnoses of malignant neoplasm of colon (cancerous tumor in the colon), diabetes mellitus (high blood sugar), and hyperlipidemia (high level fats in the blood), a BIMS of 15. Section GG 130 Self Care personal hygiene indicates resident requires setup or clean up assistance (helper sets up or cleans up). Section GG 130 Functional Abilities transfer/mobility indicates resident requires Substantial/maximal assistance (helper does more than half the effort).</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/30/25, at approximately 1:00 p.m. Resident R1 stated wait times for assistance after pushing your call light can take 20 minutes, 40 minutes, or more at times.</p> <p>Review of Resident R1's call light audit between the dates of 9/24/25 through 9/30/24, revealed call light times equal to or greater than 20 minutes.</p> <p>- 9/29/25 call light event</p> <p>28 minutes.</p> <p>- 9/30/25 call light event</p> <p>35 minutes.</p> <p>Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE].</p> <p>Review of Resident R6's Minimum Data Set (MDS-a periodic assessment of care needs) dated 8/5/25, indicated diagnoses of high blood pressure, dysphagia (difficulty swallowing) and dementia (group of diseases and illnesses that affect your thinking, memory, reasoning, personality, mood and behavior).</p> <p>During an interview on 9/29/25, at approximately 10:30 a.m. Resident R6 stated wait times for assistance after pushing call light system seems to take a while, feels like I have waited for 30 minutes or longer.</p> <p>Review of Resident R6's call light audit between the dates of 9/24/25 through 9/30/24, revealed call light times equal to or greater than 20 minutes.</p> <p>9/26/25 call light event times:</p> <p>24 minutes</p> <p>9/29/25 call light event times:</p> <p>23 minutes</p> <p>32 minutes</p> <p>Review of the clinical record indicated Resident R50 was admitted to the facility on [DATE].</p> <p>Review of Resident R50's Minimum Data Set (MDS-a periodic assessment of care needs) dated 7/23/25, indicated diagnoses of diabetes (blood sugar is too high or too low), rheumatoid arthritis (chronic condition that causes pain, swelling and irritation in the joints), radiculopathy of cervical and lumbar regions (compression or irritation of nerves in the neck and lower back causing pain, numbness and weakness in arms, legs, hips and buttocks).</p> <p>During an interview on 9/29/25, at approximately 10:40 a.m. Resident R50 stated wait times for assistance after pushing call light system seems to take a while, feels like I have waited for at least 30 minutes or longer, even as long as an hour or more.</p> <p>(continued on next page)</p>		

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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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R50's call light audit between the dates of 9/24/25 through 9/30/24, revealed call light times equal to or greater than 20 minutes.</p> <p>9/24/25 call light event times:</p> <p>23 minutes</p> <p>1 hour 24 minutes</p> <p>1 hour 33 minutes</p> <p>48 minutes</p> <p>9/25/25 call light event times:</p> <p>25 minutes</p> <p>21 minutes</p> <p>9/27/25 call light event times:</p> <p>26 minutes</p> <p>28 minutes</p> <p>29 minutes</p> <p>9/29/25 call light event times:</p> <p>31 minutes</p> <p>-</p> <p>Review of the clinical record indicated Resident R34 was admitted to the facility on [DATE].</p> <p>Review of Resident R34's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/16/25, indicated diagnoses of a hip fracture (break in the thigh bone), diabetes mellitus (high blood sugar), and hyperlipidemia (high level fats in the blood), a BIMS of 15. Section GG 130 Self Care personal hygiene indicates resident is dependent with toileting, showers, and lower body dressing (helper does all of the effort). Section GG 130 Functional Abilities transfer/mobility indicates resident requires Substantial/maximal assistance (helper does more than half the effort).</p> <p>During an interview on 9/30/25, at approximately 1:10 p.m. Resident R34 stated wait times for assistance after pushing your call light seem to take a while, I know I have waited a few occasions much more than 20 minutes to get a response.</p> <p>Review of Resident R34's call light audit between the dates of 9/24/25 through 9/30/24, revealed call light times equal to or greater than 20 minutes.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 9/25/25 call light event times</p> <p>1 hour</p> <p>47 minutes</p> <p>36 minutes</p> <p>- 9/26/25 call light event times</p> <p>20 minutes</p> <p>22 minutes</p> <p>48 minutes</p> <p>- 9/27/25 call light event time</p> <p>26 minutes</p> <p>- 9/29/25 call light event time</p> <p>22 minutes</p> <p>Review of the clinical record indicated Resident R123 was admitted to the facility on [DATE].</p> <p>Review of Resident R123's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/30/25, indicated diagnoses of a parkinson's disease (progressive movement disorder), diabetes mellitus (high blood sugar), and first digit hallux amputation (surgical removal of the toe), a BIMS of 3. Section GG 130 Self Care personal hygiene and Section GG 130 Functional Abilities transfer/mobility information was in the process of updating at the time of review and not available.</p> <p>During an interview on 9/30/25, at approximately 1:00 p.m. Resident R123 family stated they have experienced wait times longer than 20 minutes when using the call light for assistance. Family stated it seems closer to a 40-minute wait time for assistance after pushing his call light too often.</p> <p>Review of Resident R123's call light audit between the dates of 9/24/25 through 9/30/24, revealed call light times equal to or greater than 20 minutes.</p> <p>- 9/25/25 call light event times</p> <p>25 minutes</p> <p>- 9/26/25 call light event times</p> <p>34 minutes</p> <p>42 minutes</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>43 minutes</p> <p>- 9/27/25 call light event time</p> <p>50 minutes</p> <p>- 9/29/25 call light event time</p> <p>22 minutes</p> <p>Review of the clinical record indicated Resident R60 was admitted to the facility on [DATE]. Resident R60 was unavailable for an interview as she had been discharged from the facility on 9/23/25.</p> <p>Review of Resident R60's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/30/25, indicated diagnoses of a hip fracture (break in the thigh bone), hypertension (high blood pressure), and hyponatremia (abnormally low sodium), a BIMS of 14. Section GG 130 Self Care personal hygiene indicates resident is partial/moderate assistance with toileting, showers, and lower body dressing (helper does all of the effort). Section GG 130 Functional Abilities transfer/mobility indicates resident requires Substantial/maximal assistance (helper does more than half the effort) with bed and chair mobility.</p> <p>During a review of the facility grievance's revealed on 9/18/25, Resident R60 filed a grievance related to call light response/wait time. The call light log revealed a wait time of 36 minutes.</p> <p>During an interview on 10/1/25, at approximately 2:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to make certain that necessary care and services were provided for thirteen of twenty-four residents (Resident R1, R6, R34, R50, R60, R123, R500, R501, R502, R503, R505, R506, and R507).</p> <p>28 Pa. Code: 211.12(1) Nursing services.</p> <p>28 Pa. Code: 211.10(d) Resident care policies.</p> <p>28 Pa. Code: 211.12 (2)(5) Nursing services.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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]. 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 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</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>Based on a review of facility policy, observations, and staff interview, it was determined that the facility failed to make sure that medical supplies and medications were properly stored and/or disposed of in two of three medication rooms (Secure Care Unit and Dogwood Unit). Findings include: Review the facility policy Medication Labeling and Storage dated 8/13/25, indicated, If the facility has discontinued, outdated, or deteriorated medications or biologicals the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. During an observation of the Secure Care Unit nursing unit medication room on 9/30/25, at approximately 1:15 p.m. the following was observed: -(9) calcium alginate dressings with an expiration date of 5/18/24.-(1) Nasopharyngeal swab set with an expiration date of 8/19/25.-(9) Gelling fiber dressings with an expiration date of 11/2022.-(1) Dressing retention sheet roll with an expiration date of 03/2024.-(1) Latex Foley catheter with an expiration date of 4/28/23.-(1) Container of anti-fungal powder with an expiration date of 5/1/25.-(2) Sponge swabs with an expiration date of 04/2025.-(1) Bottle of povidone iodine solution with an expiration date of 12/2024.-(1) Vacutainer with an expiration date of 6/8/24.-(1) Vacutainer with an expiration date of 3/5/24.-(25) packets of Bacitracin zinc ointment with an expiration date of 09/2021. During an observation of the Dogwood nursing unit medication room on 9/30/25, at approximately 1:40 p.m. the following was observed: -(1) Contact layer dressing with an expiration date of 11/2022.-(1) Nasopharyngeal swab set with an expiration date of 1/7/25.-(1) 1ml syringe with an expiration date of 12/31/2023.-(1) Safety needle with an expiration date of 04/2020.-(1) Safety winged collection set with an expiration date of 7/15/24. Under the sink in the Dogwood medication room the following was observed:-Hearing aides for Resident R201, who discharged from the facility in June of 2022.-Hearing aides for Resident R202, who discharged from the facility in July of 2020.-Cell phone for Resident R203, who discharged from the facility in October of 2022.-(10) pairs of eyeglasses-(8) cans of energy drinks-(6) flashlights-Bag of rosary beads, folding cell phone, and other miscellaneous articles. During an interview on 9/30/25, at approximate 2:30 p.m. the Director of Nursing confirmed that the facility failed to make sure that medical supplies and medications were properly stored and/or disposed of in two of three medication rooms. 28 Pa. Code: 201.14 (a) Responsibility of licensee.28 Pa. Code: 201.18 (b)(1)(e)(1) Management.28 Pa. Code: 211.9 (a)(1) Pharmacy services.28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.</p>		

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<p>F 0944</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>Based on review of facility documents, personnel in-service training records, and staff interview, it was determined that the facility failed to provide documented training on the Quality Assurance and Performance Improvement (QAPI) Program for facility staff. Findings include: Review of the Facility Assessment dated 7/4/25, included in the list of staff training topics QAPI. Review of facility provided education documentation failed to include related to the facility QAPI program. During an interview on 10/1/25, at approximately 11:00 a.m. the Nursing Home Administrator was made aware of the surveyor's inability to find education related to the QAPI program, and was requested to confirm if any other education provided QAPI education or if possibly a class was named that it did not reveal it additionally provided QAPI education. The facility was unable to provide additional information. During an interview on 10/1/25, at approximately 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide documented training on the QAPI Program for facility staff. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.</p>		