STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396116	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Sisters of the Poor	1028 Benton Avenue Pittsburgh, PA 15212

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 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical and facility record review, facility provided documents, and staff interviews, it was determined that the facility failed to provide adequate supervision during bathing for one of three residents (Resident R1). This failure was determined to be past non-compliance. Findings include: Review of the facility policy Bath, Mechanical Lift dated November 2024, indicated before helping resident into or out of chair, lock the wheels of the carrier. Lock the carrier onto patient transfer lift. Be sure belts are tight on chair. Before moving resident, fasten seat belt onto resident. Review of the facility's Resident Bathing Safety: Quick Reference Guide dated November 2024, indicated review care plan for bathing assistance level. Stay with resident at all times. If you must step away: call another aide or nurse to stay with the resident. Never rely on just telling them to wait. Use proper lifting/transfer equipment as needed. Use all available safety mechanisms, i.e. bars, seatbelts, etc. Unsupervised bathing is a serious violation of resident rights, facility policy and federal regulations. Review of the admission Record indicated Resident R1 was admitted to the facility on [DATE]. Review of R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/13/25, indicated the diagnoses of high blood pressure, arthritis (inflammation and pain in the joints), and Schizophrenia (characterized by thoughts or experiences that seem out of touch with reality, disorganized speech or behaviors, and decreased participation in activities of daily living). Section C0500 - Brief Interview for Mental Status (BIMS -is a screening test that aids in detecting cognitive impairment) indicated a score of thirteen - cognitively intact. Review of Resident R1's current care plan, indicated resident needs assistance with activities of daily living (ADL's). Staff will assist her into the tub twice weekly. Review of Resident R1's progress note dated 9/29/25, at 7:50 a.m. indicated staff was informed that Resident R1 was in the bathing room yelling for help. At the time staff heard yelling, they ran into bathing room and found resident sliding down in the bath chair. They immediately pulled resident up in the chair and secured the safety belt. Review of facility provided documentation dated 9/29/25, at 7:35 a.m. indicated the household supervisor arrived on unit and heard screaming coming from the bathing room. Resident R1 was in bath chair sliding down and water was up to the collarbone/neck and resident was yelling, Help me, help me. Bath chair belt was not strapped, handlebar was not in front of resident, and the bath chair wheels were unlocked. When asked who put resident in the tub, resident responded The agency girl. The supervisor and another Nurse Aide (NA) drained some water and used a towel to sit resident up and strapped resident into bath chair. Once secure, the bath was completed and hair washed. Resident denied going under the water. No noted injuries. Assessment of resident: respirations easy and unlabored, lungs clear throughout, vital signs stable, and afebrile. Interview on 10/28/25, at 9:35 a.m. Resident R1 indicated recalling the episode in the bathtub. Resident indicated feeling temporarily terrified at the time of being left alone in the tub. Resident believes it was overall about ten minutes because the agency NA left immediately after placing resident in the tub. Resident stated the NA was asking the resident how the machine works, because the facility had not taught NA how to use it. Resident indicated they were not afraid of bathing and felt safe as long as the regular staff took care of resident. Interview with the Director of Nursing on 10/28/25, at 11:00 a.m. confirmed the facility failed to provide adequate supervision during bathing for one of three residents (Resident R1) and requested past non-compliance status be reviewed for the event and handed over information on immediate interventions and education that had been completed on bathing and supervision by the facility. Review of the facility's corrective actions on 10/28/25, at 2:45 p.m. verified the following had been met by the facility:-Resident R1 was immediately assisted in tub, assessed by nursing and physician with no injuries and only temporarily terrified during the time left alone in the tub.-NA Employee E1 was interviewed and immediately sent home from the facility.-Resident R1's care plan was updated on 9/29/25, indicated resident has had a bad experience while being bathed in the whirlpool. Resident will express satisfaction and comfort with their bathing routine. Resident will only be assisted with bathing by trained staff and will not be left alone during bathing. Social services to visit and monitor mood and behaviors and offer counseling to express any feelings about the incident. Staff will encourage resident to express concerns regarding bathing.-Review of Resident R1's progress notes revealed seventeen daily visits from social services from 9/29/25, through 10/27/25. Resident expressed no ill effects from the incident.-All nursing staff 66 of 66 facility nursing staff and 11 of 15 agency nurse aides were re-educated on resident bathing safety and equipment, and ensuring a resident in a tub is never left unattended -In person interviews on 10/28/25, indicated six of six NAs on site

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on review of facility education documents, and staff interview, it was determined that the facility failed to provide training on effective communication for nine of ten staff members (Nurse Aides (NA) Employee E2, NA E3, NA E4, NA E5, NA E6, NA E7, NA E9, Licensed Practical Nurse (LPN) Employee E10, and Registered Nurse (RN) Employee E11).Findings include:Review of facility provided documents and training records for NA E2, NA E3, NA E4, NA E5, NA E6, NA E7, NA E9, LPN Employee E10, and RN Employee E11 failed to include education on effective communication as required.Interview on 10/28/25, at 2:30 p.m. the Nursing Educator Employee E12 confirmed that the facility failed to provide training on effective communication for nine of ten staff members (NA E2, NA E3, NA E4, NA E5, NA E6, NA E7, NA E9, LPN Employee E10, and RN Employee E11).28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201. 18 (b)(1) Management.28 Pa Code: 201.20 (a)(6)(d) Staff development.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on review of facility education documents, and staff interview, it was determined that the facility failed to provide training on Resident Rights for one of ten staff members (Nurse Aide (NA) Employee E4).Findings include:Review of facility provided documents and training records for NA Employee E4 failed to include education on Resident Rights as required.Interview on 10/28/25, at 2:30 p.m. the Nursing Educator Employee E12 confirmed that the facility failed to provide training on Resident Rights for one of ten staff members (NA Employee E4).28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.18 (b)(1) Management.28 Pa Code: 201.20 (a)(6)(d) Staff development.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on review of facility education documents, and staff interview, it was determined that the facility failed to provide Quality Assurance and Performance Improvement (QAPI) training for three of ten staff members (Nurse Aides (NA) Employees E2, NA E3, and NA E4).Findings include:Review of facility provided documents and training records for NA Employees E2, NA E3,and NA E4, failed to include education on QAPI as required.Interview on 10/28/25, at 2:30 p.m. the Nursing Educator Employee E12 confirmed that the facility failed to provide training for QAPI for three of ten staff members (NA Employees E2, NA E3, and NA E4).28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.18 (b)(1) Management.28 Pa Code: 201.20 (a)(6)(d) Staff development.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. Based on review of facility education documents, and staff interview, it was determined that the facility failed to provide Compliance and Ethics training for three of ten staff members (Nurse Aides (NA) Employees E2, NA E3, and NA E4).Findings include:Review of facility provided documents and training records for NA Employees E2, NA E3, and NA E4, failed to include education on Compliance and Ethics as required. Interview on 10/28/25, at 2:30 p.m. the Nursing Educator Employee E12 confirmed that the facility failed to provide training for Compliance and Ethics for three of ten staff members (NA Employees E2, NA E3, and NA E4).28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.18 (b)(1) Management.28 Pa Code: 201.20 (a)(6)(d) Staff development.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on review of facility education documents, and staff interview, it was determined that the facility failed to provide Behavioral training for three of ten staff members (Nurse Aides (NA) Employee E6, NA E8, and Licensed Practical Nurse (LPN) Employee E10.Findings include:Review of facility provided documents and training records for NA Employee E6, NA E8, and LPN Employee E10 failed to include Behavioral training as required.Interview on 10/28/25, at 2:30 p.m. the Nursing Educator Employee E12 confirmed that the facility failed to provide Behavioral training for three of ten staff members (Nurse Aides (NA) Employee E6, NA E8, and Licensed Practical Nurse (LPN) Employee E10.28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.18 (b)(1) Management.28 Pa Code: 201.20 (a)(6)(d) Staff development.