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	01/22/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **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 protect a resident from neglect that resulted in actual harm resulting in a scalp laceration, requiring three staples for one of three residents reviewed (Resident R35). Findings include: Review of the facility Abuse, Neglect, mistreatment, and Misappropriation of Resident Property policy dated 11/10/25, revealed neglect is the failure of the facility, it's 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 Mechanical Lift, Use Of policy dated 11/10/25, revealed the facility wants to ensure that the residents are cared for safely while maintaining a safe work environment for employees. Nursing staff members will assess each resident prior to transferring them to determine the safest way to accomplish the transfers. It is imperative that all transfers involving the mechanical lift are to be handled with two nursing staff members present. Review of Resident R35's admission record indicated resident was admitted to the facility on [DATE], with diagnoses of Non-Alzheimer's Dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), depression, and muscle weakness. Review of Resident R35's care plan dated 12/19/22, revealed the resident required a full body lift assist of two persons for transfers. Review of the Minimum Data Set assessment (MDS- periodic assessment of resident care needs) dated 6/6/25, revealed the diagnoses were current. Section GG: Functional Abilities, Section GG0170 indicated Resident R35 was dependent on staff for bed to chair transfers. Review of Resident R35's progress note dated 8/20/25, revealed Resident R35 slipped out of lift pad and onto floor. The resident was laying on their back on the floor; bleeding was observed from the back of head. The physician was notified and the resident was transferred to the hospital for evaluation. Review of Resident R35's hospital records dated 8/20/25, revealed Resident R35 sustained scalp laceration following a fall. Resident R35 required three staples. Review of Nurse Aide (NA) Employee E3's witness statement dated 8/20/25, revealed NA Employee E3 walked into Resident R35's room looking for help with a transfer for another resident. NA Employee E1 had Resident R35 in the Hoyer lift and out of her wheelchair. Resident R35 was not hooked up properly in the lift. The straps were not all hooked to the lift, and Resident R35 was leaning forward with the upper straps around her neck and shoulders. While NA Employee E3 was trying to get Resident R35 to the bed, NA Employee E1 was watching me and not helping me and Resident R35 fell out of the sling and onto the floor. Review of Registered Nurse (RN) Employee E4's witness statement dated 8/20/25, revealed the resident was observed on the floor, lying on back. It was revealed resident slid out of lift pad during lift and landed on floor. Bleeding noted on floor from back of resident's head. Physician was notified and the resident was sent to hospital for further evaluation. Review of report submitted on 8/21/25, revealed Resident R35 was transferred to the hospital (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 0600 Level of Harm - Actual harm Residents Affected - Few	following an injury during a transfer. NA Employee E1 initially hooked the resident up to a whole-body lift, she lifted the resident up from chair with lift and started to move from wheelchair to bed. NA Employee E3 entered the room to help move her, but sling was not on right and they both tried to help move her to the bed fast, but she slid through the lift to floor. The resident returned back to the facility with three staples to back of head. Review of NA Employee E2's witness statement dated 8/21/25, revealed on Monday, 8/18/25, NA Employee E1 was observed coming out of Resident R35's room around 8:30 p.m. by herself pushing the full body lift. NA Employee E2 asked NA Employee E1 if she put Resident R35 in bed by herself and she said no. NA Employee E2 said Ok good because you must always be two people for the lift. Review of NA Employee E1's witness statement dated 8/22/25, indicated while in the process of putting Resident R35 to bed, it was noticed the resident was going to fall on the side. Resident R35 fell out of the side of the sling onto the floor Review of the facility incident report dated 8/31/25, revealed on 8/20/25, at 9:15 p.m., NA Employee E1 transferred Resident R35 from high back wheelchair to bed, and the resident slid out of lift pad and fell onto floor. NA Employee E1 should have double checked lift was on properly. The resident returned back to the facility with three staples to the back of head. During an interview on 1/20/26, at 1:20 p.m. NA Employee E2 stated a few days before Resident R35 was injured on 8/20/25, NA Employee E1 was observed coming out of the room with the lift and asked her if she transferred the resident by herself. NA Employee E2 informed NA Employee E1 to ensure two people assist with the lift at all times. NA Employee E2 stated then on 8/20/25, NA Employee E3 walked into Resident R35's room, and the resident was in the air, and the sling only had two rings attached instead of three. During an interview on 1/20/26, at 1:22 p.m. the Director of Nursing revealed NA Employee E1 was terminated after the incident involving Resident R35. During an interview on 1/20/26, at 1:41 p.m. RN Employee E4 stated she recalls Resident R35, and in order to transfer her from out of bed to wheelchair, a lift must be used, and two people must be used. Someone can hook up, but we always double check, never transfer without lifting. It was revealed on that particular day, NA Employee E1 hooked Resident R35 to the Hoyer lift to transfer her from her wheelchair to bed and was transferring her by herself. The resident fell out of lift pad onto floor. It was revealed the resident required three staples to her scalp. During an interview on 1/20/26, at 2:20 p.m. NA Employee E3 stated I needed assistance from another aide, and when I entered into Resident R35's room, I found the resident was already out of the chair, in the air. NA Employee E3 indicated the resident's lift pad wasn't properly hooked up by NA Employee E1. There was not a middle hook attached. Resident R35 was bent forward, and there was no safe way to put her back in the chair. When NA, Employee E3 attempted to transfer the resident in the bed, the resident fell out and fell on their head. It was indicated NA Employee E1 was near the head of the resident. Review of NA Employee E1's personnel file on 1/22/26, revealed a hire date of 7/7/25, and NA, Employee E1 received NA training and competencies for activity of daily living training, mechanical lift and safety, and transferring residents using a mechanical lift on 7/7/25. During an interview on 1/22/26, at 10:04 a.m. the Director of Nursing confirmed the facility failed to protect a resident from neglect that resulted in actual harm resulting in a scalp laceration, requiring three staples for one of three residents reviewed (Resident R35). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 201.20(b)(1) Staff Development. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.11(d) Resident care plan.