

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395606	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/20/2024
NAME OF PROVIDER OR SUPPLIER  John J Kane Regional Center-Ro		STREET ADDRESS, CITY, STATE, ZIP CODE  110 McIntyre 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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49469</p> <p>Based on review of clinical records, and staff interview it was determined that the facility failed to notify the resident's representative of a change in prescribed medication for Resident R1.</p> <p>Findings include:</p> <p>Review of facility policy Notification of Change in Residents Condition and Treatment Changes, last reviewed 1/3/24, indicate it is the policy of the [NAME] J. [NAME] Regional Centers to fully inform residents or responsible parties when applicable, in language that he or she can understand of his or hers health status including significant changes in condition or treatment.</p> <p>Review of Resident R1's clinical record indicate an admitted [DATE], with the diagnosis of acute respiratory failure (not enough oxygen in the body), muscle weakness, dysphagia (difficult swallowing).</p> <p>Review of Resident R1's medication administration record (MAR) indicate orders 2/19/24 -2/21/24, azithromycin 500 milligram tablet, 1 tablet hour of sleep for 3 days diagnosis cough, pneumonia. MAR indicates resident received.</p> <p>Review of Resident R1's progress note 2/19/24, indicate resident was started on antibiotic for pneumonia. No notification to family was noted.</p> <p>During an interview on 2/20/24, 1:53 p.m. the Director of Nursing confirmed that the facility failed to notify the resident's representative of a change in prescribed medications for Resident R1.</p> <p>28 Pa. Code 201.18(b)(1) Management.</p> <p>28 Pa. Code 201.29 (a) Resident rights.</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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