STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395606	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John J Kane Regional Center-Ro	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785 Based on review of facility policy, clinical records, security footage, facility documents, and staff interviews, it was determined that the facility failed to provide adequate supervision resulting in an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one out of four sampled residents (Resident R1). This deficiency is cited as past non-compliance. Finding include: The facility Elopement: missing resident policy dated 12/30/21, indicated that it is the policy of the facility to provide each resident with receive adequate monitoring and interventions to maintain safety. When a resident is unaccounted for all staff will report any suspected unplanned resident absence to the Supervisor or charge nurse. Review of Resident R1's admission record indicated he was admitted on [DATE]. Review of Resident R1's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 2/19/24, indicated that Resident R1 had diagnoses that included a history of vertebra fracture, chronic kidney disease (a loss of kidney function resulting in the swelling of feet, fatigue, high blood pressure and changes in urination), coronary artery disease (blood vessels suffer blockages resulting in reduced blood supply to major arteries), Dementia (a condition characterized by memory loss and progressive or persistent loss of intellectual functioning), and a paralytic gait (a person with walking pattern characterized by weakness on one side or other gait abnormalities). Review of Resident R1's care plan dated 3/24/24, indicated to encourage Resident R1 to remain in common areas such as the nursing station and the dining room at all times for increased supervision. (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	Review of Resident R1's clinical progress notes dated 5/6/24, indicated that Resident R1 observed sitting on buttocks in grass outside of facility employee entrance. Wheelchair within close proximity. When asked how he made it outside, Resident R1 replied I walked. Resident R1 remained alert and verbal. Denied any pain. Resident R1 transferred into wheelchair via staff assistance. Resident R1 maintained range of motion in all extremities. Pupils remain equal and reactive. Resident R1 noted to have small skin tear to lower left extremity. Resident R1 was assisted back inside building. Wanderguard placed. Neurological checks initiated. Physician made aware. Call placed to Power of attorney. The security shift report dated 5/6/24, indicated that between 6:36 p.m. and 6:41 p.m. Security guard Employee E5 was assisting staff with a new admission and then helped staff open the respiratory room. Review of Security guard Employee E5 witness statement dated 5/6/24, indicated that at around 6:50 p.m. a lady entered the main building stating Resident R1 was on the ground outside. Security guard Employee E5 checked the camera and went to the scene. Security guard Employee E5 arrived around 6:54 p.m. and told Resident R1 to stay where he was and not to move. Registered Nurse (RN) Supervisor Employee E2 was contacted. Registered Nurse (RN) Supervisor Employee E2 , Nurse aide Employee E3 and Nurse aide Employee E4 came outside, assessed Resident R1 and helped him back inside. Review of security footage showed that if you employee exit was pulled hard enough, the magnetic lock would disengage. Review of Dietary aide Employee E1's witness statement dated 5/7/24, indicated that Dietary aide Employee E1 saw Resident R1 on the first floor, opened the double doors for Resident R1, and did not think anything was wrong because the wander guard alarm did not go off near the double doors. Review of maintenance service request dated 5/7/24, indicated that employee exit magnetic lock disengaged when given a firm push. Review of service provider inservice dated 5/7/24, indicated that rust and debris on employee exit. Magnetic lock now working. Review of security footage on 5/9/24 at 9:23 a.m. with the Nursing Home Administrator (NHA), indicated the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/24, at 6:27 on 3-East, Resident R1 wandered towards elevators. At 6:28 p.m. Resident R1 pushed the elevator button and got on the elevator. He exited the elevator at 6:29 p.m. on the first floor. Resident R1 turned right and proceeded down the hallway past the kitchen. He proceeded through the double doors at 6:31 p.m. Dietary aide Employee E1 walked past the Resident R1 as he wandered through double doors. Dietary aide Employee E1 was observed on his cell phone. Resident R1 proceeded down first floor hallway until he was at an employee exit. Resident R1 pushed on the employee exit multiple times until the door released and Resident R1 exited the facility at 6:32 p.m. Resident R1 then proceeded outside the employee back entrance. He stopped at a concrete walkway at 6:33 p.m. as his wheelchair was stuck in the grass. He then placed himself on his knees at 6:41 p.m. to move and manipulate the wheelchair while in the grass. He began to move the wheelchair while still on his knees from 6:41 p.m. to 6:44 p.m. At 6:44 p.m. he stopped and layed in the grass on his left side. At 6:45 p.m. a bystander from the apartment building located near the facility found him and went to his assistance. She attempted to enter employee entrance/exit, however, it was locked. At 6:48 p.m. a bystander told security that Resident R1 was outside. At 6:52 p.m. Registered Nurse (RN) Supervisor Employee E2 observed the bystander with Resident R1 and entered facility to get assistance. Resident R1 continued laying on the grass. At 6:53 p.m. two other nursing staff (Nurse aide Employee E3 and Nurse aide Employee E4) exited the employee entrance, and spoke to security about the situation. At 6:57 p.m. Registered Nurse (RN) Supervisor Employee E2 observed with nursing staff (Nurse aide Employee E3 and Nurse aide Employee E4) to assist and assess Resident R1. During an interview on 5/9/24, at 10:08 a.m. the Nursing Home Administrator (NHA) stated that security staff were not at the desk at the time of the incident because they were opening respiratory staff door for a LPN. We have had the door latch and magnetic section cleaned and repaired. I believe the door latch failed. On 5/9/24, at 12:14 p.m. Registered Nurse (RN) Supervisor Employee E2 was contacted via phone for her statement. During a phone interview on 5/9/24, at 12:29 p.m. Nurse aide Employee E6 stated: I don't know to much about the elopement. I was sitting at the nurse's station. The 7 p.m. shift supervisor informed us that Resident R1 was outside on the ground. We went outside. The Registered Nurse (RN) Supervisor Employee E8 did an assessment. I was not his caretaker for the day. From what I know, all the doors have locks on them. You cannot get out the building as well as there are cameras. Security does rounds. We have a check list and do rounds. During an interview on 5/9/24, at 12:07 p.m. Nurse aide Employee E7 stated: I was working the evening of 5/6/24. I was in a resident room doing care. A nurse asked who had Resident R1. She told me he was outside on the ground. Me and two other nurse aides went out there. We did the vitals and assisted him upstairs. We did more vitals once he was upstairs. The nurse did an assessment on him. He had a few bruises. Overall, he was o.k. On 5/9/24, at 1:56 p.m. Dietary aide Employee E1 was contacted via phone for his statement. On 5/6/24, the facility initiated plan of correction actions which included: Audits of wander guards to ensure they are working Resident R1 neurochecks after the elopement incident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Re-evaluation of all residents for Elopement risk Discipline of dietary aide/termination Security checks to make sure the all doors work properly Staff re-education on elopement, elopement policy Staff re-education to check exits and ensure they lock Staff re-education on elopement policy included: 1)Dialing 444 and calling a code [NAME] alert 2) Reporting suspected unplanned resident absence 3) Accountability binders with list of wandering residents During staff interviews on 5/10/24, starting at 9:43 a.m. 12 facility staff (Housekeeping aide Employee E9, housekeeping foreman Employee E10, Dietary aide Employee E11, Licensed Practical Nurse Employee E12, Nurse aide Employee E13, Nurse aide Employee E14, Nurse aide Employee E15, Registered Nurse Employee E16, Cook Employee E17, Secretary Employee E18, Therapeutic Recreation supervisor Employee E19, and Environmental Service manager Employee E20) were interviewed to determine appropriate re-education was conducted as part of corrective actions. During observations, review of education documents, and staff interviews, it was verified that the facility had implemented a plan of correction to ensure adequate resident supervision and had achieved substantial compliance as of 5/8/24. During an interview on 5/10/24, at 12:03 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to provide adequate supervision resulting in Resident R1's elopement, provided verifiable information that the facility had implemented a plan of correction and achieved compliance to make certain that adequate supervision is provided to residents. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services