

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 02/03/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>35785</p> <p>Based on facility policy review, facility documents, and staff interviews, it was determined that the facility failed to implement procedures to promote accurate accounting of controlled medications and ensure medication cart keys were provided to staff in accordance with professional standards during a shift to shift change on one out of six medication carts (3-West low hall).</p> <p>Findings include:</p> <p>The facility Medications-narcotics, controlled substances policy last reviewed on 1/2/25, indicated that the medication key exchange included conducting a physical inventory of medications in the locked medication drawer every time medication keys are exchanged, the departing nurse reviewing the inventory form, the receiving nurse visualizing each medication in the drawer, the receiving nurse checking the narcotic disposition record, and both nurses signing the appropriate form.</p> <p>The facility Licensed Practical Nurse (LPN) job description last reviewed on 1/2/25, indicated that the LPN will ensure that medication and narcotics are completed accurately in accordance with established policies.</p> <p>Review of the 3-West low hall medication shift-to-shift change form was signed on 1/23/25, at 3:00 p.m. by Agency Licensed Practical Nurse (LPN) Employee E2</p> <p>Facility documents dated 2/3/25, indicated that Agency Licensed Practical Nurse (LPN) Employee E2 had a busy day and left her post after giving report. She left the building because her son would be late for work.</p> <p>(continued on next page)</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/3/25, at 1:16 p.m. Registered Nurse (RN) Supervisor Employee E3 stated the following: I was the supervisor that day on 1/23/25. I got a call from Agency Licensed Practical Nurse (LPN) Employee E2, I went over to 3-West around 4 pm. She stated she left the building and she stated she left the keys in her jacket and the keys were in the car that her son took. She stated she left keys in white lab coat. I did not see her leave. She stated her son had the car and she will be back around 7:00 p.m. Licensed Practical Nurse (LPN) Employee E4 stated that there was no keys for the medication cart. Agency Licensed Practical Nurse (LPN) Employee E2 did not count with Licensed Practical Nurse (LPN) Employee E4 before she left. Around 5:30 p.m. Licensed Practical Nurse (LPN) Employee E4 contacted security, and got a hold of the medication cart keys for the 3-West low hall medication cart. Staff should not just leave after the shift is through. When starting a shift, before you give the medication, a nurse has to count the medication and get the keys for that cart.</p> <p>During an interview on 2/3/25, at 1:34 p.m. Licensed Practical Nurse (LPN) Employee E4 stated the following: On 1/23/25, I was already working 7 a.m. to 7 p.m. I was switching sides to the low side of the 300-hall. I was speaking to a family member. Around 3:40 p.m. As I was walking out of the room, Registered Nurse (RN) Supervisor Employee E3 stated Agency Licensed Practical Nurse (LPN) Employee E2 left with the keys and would be back at a later time. I told him that I would not touch cart until it was counted with another nurse. We counted the cart/Registered Nurse (RN) Supervisor Employee E3 and I , and it was off by two medications. Both were narcotics. Agency Licensed Practical Nurse (LPN) Employee E2 never counted the narcotics in the Medication cart 300 low hall with me. The normal procedure when the nurse comes in, you both count the cards and the number of narcotics in each card. You must make sure they match. And that is kind of the end of the process. And they give you the medication cart keys. Any discrepancies, you must stop and get a supervisor involved until something is corrected. I had already counted with the other nurse on the high 300 hallway.</p> <p>During an interview on 2/3/25, at 3:07 p.m. the Director of Nursing (DON) confirmed that the facility failed to implement procedures to promote accurate accounting of controlled medications and ensure medication cart keys were provided to staff in accordance with professional standards during a shift to shift change on 1/23/25 for the 3-West low hall medication cart as required.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</p> <p>28 Pa. Code 211.19(a)(1)(k) Pharmacy services</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>35785</p> <p>Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to store medications securely in one out of six medications carts (3-West Low hall medication cart).</p> <p>Findings include:</p> <p>The facility Medication administration general guidelines policy last reviewed 1/2/25, indicated that all medications must be kept secured and in a locked environment.</p> <p>During observations on 2/3/25, at 12:13 p.m. observations of the 3-West unit found the 3-West low hall medication cart was observed unlocked. No registered nurse, licensed practical nurse or any other staff observed securing the cart.</p> <p>During observations on 2/3/25, at 12:17 p.m. observations of the 3-West unit found the 3-West low hall medication cart #1 observed unlocked. No registered nurse, licensed practical nurse or any other staff observed securing the cart.</p> <p>During an interview on 2/3/25, at 12:18 p.m. Assistant Director of Nursing (ADON) Employee E1 confirmed that the facility failed to store medications securely in one out of six medications carts as required.</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy services.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>