

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 08/06/2025
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)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical records, facility documents, and staff interviews, it was determined that the facility failed to permit a readmission to the facility after hospitalization and failed to demonstrate in the clinical record that the discharge was appropriate and necessary for one of three sampled closed resident records (Closed Resident Record CR1). Findings include: The facility Discharge and transfer policy dated 4/28/25, indicated that discharge criteria included to discharge as necessary to meet the resident's welfare and when the resident's welfare and physical needs cannot be met in the facility. The Facility assessment last updated 6/30/25, indicted that common diagnoses that residents in facility have are depression, impaired cognition and behaviors that need intervention. The assessment further indicated that staff are trained on specific areas that relate to psychiatric symptoms, provide interventions dealing with depression and anxiety. Review of Closed Resident Record CR1's admission record indicated she was originally admitted on [DATE]. Review of Closed Resident Record CR1's Minimum Data Set (MDS - a periodic assessment of resident care needs) assessment dated [DATE], indicated that she had diagnoses that included right femoral fracture, hypertension (a condition impacting blood circulation through the heart related to poor pressure), and congestive heart failure (a progressive heart disease affecting pumping action of the heart muscles impacting circulation, swelling and shortness of breath). Review of Closed Resident Record CR1's care plans dated 5/23/25, indicated to monitor for signs and symptoms of mood and depression. Facility documents submitted to the State dated 7/21/25, indicated the following: Closed Resident Record CR1 was found during morning rounds at approximately 4:48am lying on the floor (head at the bottom of the bed) with a phone charger cord wrapped around her neck and a plastic bag covering her head. Upon assessment, Closed Resident Record CR1 verbalized multiple times, I want to die. No prior verbalizations of suicidal intent were reported during the most recent rounds. Closed Resident Record CR1 was alert and oriented and very aware of the situation. Vital signs stable. No active bleeding or trauma noted. Mild redness noted around neck observed, no skin breakdown or open wounds at that time. A plastic bag and cord were removed immediately and secured. Closed Resident Record CR1 exhibited clear suicidal ideation with a recent attempt to harm herself. Psychiatric emergency. Safety risk to self. Voice message left for Power of Attorney (POA). Doctor notified with orders to send to the emergency room for further evaluation. Facility documents and staff statements dated 7/21/25, indicated that Registered Nurse (RN) Employee E3 witness summary of incident: I was at my cart and an aide said, 'Closed Resident Record R1 was on the floor with a bag over her head.' I went into the room and found another aide unwrapping the phone cord from around her neck. The aide said she took the bag off her head when she called for help. Review of Closed Resident Record CR1's behavior and mood event nurse assessment dated [DATE], indicated suicide attempt occurred, she made repeated comments that she wanted to die, and to send her to emergency room for further evaluation. Review of Closed Resident Record CR1's discharge letter dated 7/21/25, indicated that the facility was unable to provide necessary care and services for the Resident's wellbeing. Review of Closed Resident Record CR1's bed hold authorization form dated 7/21/25, indicated that Director of Social Services Employee E2 reviewed the bed hold form and the family wanted her bed held. Review of Closed Resident Record CR1's clinical progress noted dated 7/22/25, indicated that her POA was called and was told the resident would return to the facility. Staff explained that the Closed Resident Record CR1 was officially discharged from the nursing facility. Closed Resident Record CR1's progress notes further indicated that her belongings were packed and placed in the conference room. Review of Closed Resident Record CR1's clinical record, medical history or nurse assessments did not indicate any medical reason that she could not return. The record related to the basis for discharge did not clearly indicate via clinical assessment why the facility could no longer care for Closed Resident Record CR1 needs. During an interview on 8/6/25, at 12:10 p.m. Registered Nurse (RN) Employee E1 stated the following: Closed Resident Record CR1 was here on 2-East about two months. She was doing well with us. I know she had a family member visit, and afterwards she seemed a bit sad. She would go to mass and started to be more social. We had orthopedic appointment follow-up for her setup. When I spoke to her with therapy present, she wanted therapy and wanted to stand again. Overall, she was sweet and agreeable. We would ask her if things were ok, she would say 'yes'. During an interview on 8/6/25, at 12:40 p. m. Director of Social Services Employee E2 stated: Closed Resident Record CR1 has been here three months. I've seen her here and there. She had no behaviors prior to the incident. I usually check the</p>		