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	12/11/2025

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 0600 Level of Harm - Minimal harm or potential for 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. (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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and documentation, staff and resident interviews it was determined that the facility failed to protect residents from neglect for one of two residents (Resident R1).Findings include: Review of facility policy Abuse, Resident and Reasonable Suspicion of a Crime, dated 1/2/25, indicated that facility will treat every resident with consideration, respect, and full recognition of his/her dignity and individuality. Definition of neglect is defined by the failure of the facility, the staff, or service providers to provide goods and services to a resident that are necessary to avoid or may result in physical harm, pain, mental anguish, or emotional distress. Review of the facility policy Catheter Care and Drainage Bags last reviewed 1/2/25, indicated to provide nursing staff with instructions to safely and appropriately provide hygiene for residents with indwelling urinary catheters. Review of the facility job description for Nursing Assistant (NA), indicated that staff will provide routine daily individualized nursing care and services in a safe and effective manner using therapeutic interactions in accordance with the resident's assessment and care plan to assure that the highest degree of quality resident care is maintained at all times. Duties and responsibilities include delivers care in accordance with the daily review of the resident ‘s care plan, provides personal hygiene to residents such as bathing, toileting incontinent residents, and grooming. Utilizes safe techniques in care of residents. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review Resident R1's Minimum Data Set (MDS, periodic assessment of resident care needs) dated 10/13/25, indicated the diagnosis of traumatic spinal cord dysfunction, anemia (low iron in the blood) and neurogenic bladder (lack of bladder control due to brain, spinal cord or nerve problems) Review of Section GG: Toilet hygiene indicated Resident R1 was dependent on staff (Helper does ALL of the effort. Residents do none of the effort to complete the activity). Review of a physician order dated 10/1/25, indicated Suprapubic foley catheter (tube that drains urine from the bladder placed through a small incision in the abdomen) diagnosis neurogenic bladder. Review of Resident R1's care plan dated 11/26/25, with revision 12/5/25, indicated problem: Trauma wound to right anterior medial shin. Approach: string will be used to hang foley bag not plastic clip. Review of nursing progress notes dated 11/26/25, at 11:17 a.m. indicated at 10:40 a.m. the aid reported a skin tear to this nurse. Measuring 4.3 x 2.7 on the right anterior medial shin. The wound has scant bleeding with wound weeping due to edema in the extremity. The resident reports a pain level of 3/10 which no pain meds where requested. According to the reporting aid the wound is from the resident's catheter bag being placed down the leg of the resident's pants while being dressed. Registered Nurse was notified as well as in house wound care. Order was given to send resident of to the hospital for evaluation. Xeroform was placed on wound then wrapped for transport. Review of nursing progress note dated 11/26/25, at 12:03 p.m. indicated notified by nurse that resident sustained a laceration to right anterior medial shin when staff were putting on her pants the hook from urine bag caught her leg causing the laceration, it's v-shaped skin flap attached at wound bed edges well approximated fatty tissues visible with clear serosanguinous discharge draining/weeping surrounding skin shinny fragile edematous physician assistant present in room assessed the tear orders for emergency room transfer for suture placement. Review of nursing progress notes dated 11/26/25, at 2:31 p.m. indicated resident returned from hospital. Per report from emergency room with Registered Nurse the wound was non-reparable due to wound weeping and skin integrity. Wound was closed with steri-strips. Review of investigation statement dated 11/26/25, Employee E14 was noted as the investigator: Describe what happened: sustained tear from the urinary bag hook while dressing. Dressed in leggin pants by staff. Care plan approach: staff educated for safety, not to place urine bag in pants while dressing residents. Noted on form education dated 11/26/25, lessen risk of injury for residents with foley catheter and do not attempt to thread leg bag with hook thru leggings, four signatures were noted. Review of investigation statement dated 11/26/25, Employees E2 indicated when putting the tubing down the right side of leg the hook from the urine bag caught her leg causing tear. Review of investigation statement dated 11/26/25, Employee E15 indicated: noticed skin tear on resident after foley tubing was put down pants. Review of facility submitted information dated 11/26/25, indicated that Resident R1 sustained a laceration to right anterior medial shin when staff were putting on her leggings/pants from the hook from urine bag. During an interview completed on 12/11/25, at 11:00 a.m. the Nursing Home Administrator (NHA) stated that Resident R1 has lymphedema and frail skin contributing to skin laceration and she also has very tight pants. During an interview completed on 12/11/25, at 12:05 p.m. upon asking Resident R1 if she could recall the

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility documents, clinical record review, and staff interview it was determined that the facility failed to revise a care plan to accurately reflect the current status for one of three residents (Resident R1).Findings included:Review of the facility Assessment -Comprehensive Person-Centered Care Planning last reviewed 1/2/25, indicated to assure documentation, development, and implementation of a comprehensive person-centered care plan for all residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review Resident R1's Minimum Data Set (MDS, periodic assessment of resident care needs) dated 10/13/25, indicated the diagnosis of traumatic spinal cord dysfunction, anemia (low iron in the blood) and neurogenic bladder. Review of Resident R1's physician orders dated 12/10/25, indicated right anterior lower extremity trauma wound, leave open to air allow steri- strips to fall off. Review of nursing progress note dated 11/26/25, at 12:03 p.m. indicated notified by nurse that resident sustained a laceration to right anterior medial shin when staff were putting on her pants the hook from urine bag caught her leg causing the laceration, it's v-shaped skin flap attached at wound bed edges well approximated fatty tissues visible with clear serosanguinous discharge draining/weeping surrounding skin shinny fragile edematous. During an interview completed on 12/11/25, at 11:00 a.m. the Nursing Home Administrator (NHA) stated that Resident R1 has lymphedema and frail skin. During an interview completed on 12/11/25, at 1:45 p.m. upon asking Nurse Aid (NA) Employee E2 concerning Resident R1's leg appearance indicated they are sometimes swollen and leak, that she also has special pumps that she uses. Review on 12/11/25, at 1:30 p.m. Resident R1's current care plan failed to include any interventions for lymphedema or preventative measures for impaired skin integrity. During an interview completed on 12/11/25, at 2:45 p.m. Registered Nurse Employee E16 confirmed that Resident R1's current care plan did not include interventions for lymphedema or preventative measures for impaired skin integrity. During an interview completed on 12/11/25, at 3:10 p.m. the Nursing home Administrator confirmed that the facility failed to revise a care plan to accurately reflect the current status for one of three residents (Resident R1). 28 Pa. Code 211. 12(d)(1)(3)(5) Nursing Services.28 Pa. Code 211.11(e) Resident Care Plan.