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	04/22/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy and clinical record review, it was determined that the facility failed to protect residents from neglect due to lack of supervision resulting in an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one of three residents (Closed Record Resident CR1). Findings include: Review of facility policy Abuse - Resident and Reasonable Suspicion of a Crime, dated 1/2/25, indicated that the facility is to treat every residents with consideration, respect and full recognition of his/her dignity and individuality. This policy is part of the centers overall prevention of abuse, neglect, exploitation of residents, and misappropriation of resident property program. Purpose to provide direction to staff regarding procedures required to protect residents from abuse, to respond appropriately to allegations, to satisfy reporting and notification obligations, and to conduct investigations.Definitions:Neglect - the failure of the facility, the staff, or service provider 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.Abuse or neglect of residents will not be tolerated, and any suspected occurrence will be investigated promptly and with discretion. Alleged violations, whether or not confirmed, must be reported to the Administrator, PA Department of Health (DOH), the Area Agency on Aging, Compliance Officer, and to the Executive Director, and a full investigation conducted. Review of facility policy Wanderguard and Elopement Policy, dated 1/2/25, indicated it is the policy of the facility to implement safety measures for resident who wander and/or are at risk for elopement to attempt to prevent elopement.Definitions:Wandering - random or repetitive locomotion. This may be movement may be goal-directed or may be non-goal-directed or aimless. Non-goal-directed wandering requires a response in a manner that addresses both safety issues and an evaluation to identify root causes to the degree possible.Elopement - when a resident leaves the premises or safe area without the facilities knowledge and supervision. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2025, indicated that a Brief Interview for Mental Status (BIMS), is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of the clinical record indicated Resident CR1 was originally admitted to the facility on [DATE]; was discharged to another facility 3/18/26. Review of the Resident CR1's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 12/3/25, included diagnoses of multiple sclerosis (autoimmune disease that affects the central nervous system, leading to damage of the myelin sheath that protects nerve fibers, resulting in a range of physical and cognitive symptoms) , dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities) and cognitive communication deficit (condition where cognitive impairments disrupts a person's ability to communicate effectively, despite intact language and speech ability). Review of Section C: Cognitive Patterns indicated Resident CR1 had a BIMS score of 3, severe impairment. Review of Section E: Behavior indicated Resident CR1 had not exhibited wandering behavior. Review of Section P: Restraints and Alarms (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	indicated wander/elopement alarm was used daily. Review of physician order dated 5/16/25, indicated to check function of wander guard (a safety system designed to prevent at-risk residents, such as those with dementia, from leaving a care facility unsupervised, using wearable devices and door monitoring technology) daily on 11-7, Special instruction: Function check once a day 11:00 p.m. - 7:00 a.m. Review of physician order dated 7/9/25, indicated wander guard AAT's (at all times) check placement and documents every shift, Special instructions: 827066 (wander guard ID number) every shift, days, eve, nights. Review of physician order dated 6/24/25, indicated (Resident CR1) - may move about the floor without supervision but may not exit the unit/safe area without supervision. Review of physician order dated 6/10/24, indicated ADL (Activities of Daily Living) - Ambulation: Assist x1/Supervision for 300 feet without wheeled walker, every shift days, eve, nights. Review of physician clinical progress note dated 12/9/25,at 7:15 p.m., indicated seeing her (Resident CR1) today for staff reporting possible UTI (urinary tract infection) due to AMS (altered mental status) and wandering. Review of nurse clinical progress note dated 12/23/25, at 6:34 a.m., revealed while staff members were doing am (morning) rounds with other residents, second floor staff brought resident (CR1) to the unit and that resident (CR1) was on their unit looking for breakfast, second floor staff notified supervisor, resident denies pain/discomfort, no complaints, RLE (right lower extremity) wander guard monitor still in place. Nurse aide monitoring resident (CR1) by her room, and nurse aide re-directing resident, resident cooperative with redirection, safety maintained. During an interview on 4/22/26, at 1:55 p.m., Resident Nurse Assessment Coordinator (RNAC) Employee E1, former Director of Nursing (DON) in 12/2025, revealed that she was unaware of Resident CR1 being found on the second floor on 12/23/25, and only became aware of incident on 4/22/26, confirming that the facility failed to protect residents from neglect due to lack of supervision resulting in an elopement for Closed Record Resident CR1. 28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(b)(1)(3) Management.28 Pa. Code 201.29(a) Resident Rights28 Pa. Code 211.10(c)(d) Resident Care Policies.28 Pa. Code 211.12(d)(1)(3) Nursing services.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and exploitation with a complete and thorough investigation of an incident involving an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one of three residents (Closed Record Resident CR1).Findings include: Review of facility policy Abuse - Resident and Reasonable Suspicion of a Crime, dated 1/2/25, indicated that the facility is to treat every residents with consideration, respect and full recognition of his/her dignity and individuality. This policy is part of the centers overall prevention of abuse, neglect, exploitation of residents, and misappropriation of resident property program. Purpose to provide direction to staff regarding procedures required to protect residents from abuse, to respond appropriately to allegations, to satisfy reporting and notification obligations, and to conduct investigations.Definitions:Neglect - the failure of the facility, the staff, or service provider 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.Abuse or neglect of residents will not be tolerated, and any suspected occurrence will be investigated promptly and with discretion. Alleged violations, whether or not confirmed, must be reported to the Administrator, PA Department of Health (DOH), the Area Agency on Aging, Compliance Officer, and to the Executive Director, and a full investigation conducted. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2025, indicated that a Brief Interview for Mental Status (BIMS), is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of the clinical record indicated Resident CR1 was originally admitted to the facility on [DATE]; was discharged to another facility 3/18/26. Review of the Resident CR1's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 12/3/25, included diagnoses of multiple sclerosis (autoimmune disease that affects the central nervous system, leading to damage of the myelin sheath that protects nerve fibers, resulting in a range of physical and cognitive symptoms) , dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities) and cognitive communication deficit (condition where cognitive impairments disrupts a person's ability to communicate effectively, despite intact language and speech ability). Review of Section C: Cognitive Patterns indicated Resident CR1 had a BIMS score of 3, severe impairment. Review of nurse clinical progress note dated 12/23/25, at 6:34 a.m., revealed while staff members were doing am (morning) rounds with other residents, second floor staff brought resident (CR1) to the unit and that resident (CR1) was on their unit looking for breakfast, second floor staff notified supervisor, resident denies pain/discomfort, no complaints, RLE (right lower extremity) wander guard monitor still in place. Nurse aide monitoring resident (CR1) by her room, and nurse aide re-directing resident, resident cooperative with redirection, safety maintained. During an interview on 4/22/26, at 1:55 p.m., Resident Nurse Assessment Coordinator (RNAC) Employee E1, former Director of Nursing (DON) in 12/2025, revealed that she was unaware of Resident CR1 being found on the second floor on 12/23/25, and only became aware of incident on 4/22/26. RNAC Employee E1 confirmed that the facility failed to implement written policies and procedures to prohibit and neglect with a complete and thorough investigation of an incident involving an elopement for Resident CR1. 28. Pa Code 201.14(a) Responsibility of licensee.28. Pa Code 201.18(b)(1)(e)(1) Management.28. Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to implement policies and procedures to report an incident of neglect for one of three residents (Closed Record Resident CR1).Findings include: Review of facility policy Abuse - Resident and Reasonable Suspicion of a Crime, dated 1/2/25, indicated that the facility is to treat every residents with consideration, respect and full recognition of his/her dignity and individuality. This policy is part of the centers overall prevention of abuse, neglect, exploitation of residents, and misappropriation of resident property program. Purpose to provide direction to staff regarding procedures required to protect residents from abuse, to respond appropriately to allegations, to satisfy reporting and notification obligations, and to conduct investigations.Definitions:Neglect - the failure of the facility, the staff, or service provider 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.Abuse or neglect of residents will not be tolerated, and any suspected occurrence will be investigated promptly and with discretion. Alleged violations, whether or not confirmed, must be reported to the Administrator, PA Department of Health (DOH), the Area Agency on Aging, Compliance Officer, and to the Executive Director, and a full investigation conducted. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2025, indicated that a Brief Interview for Mental Status (BIMS), is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of the clinical record indicated Resident CR1 was originally admitted to the facility on [DATE]; was discharged to another facility 3/18/26. Review of the Resident CR1's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 12/3/25, included diagnoses of multiple sclerosis (autoimmune disease that affects the central nervous system, leading to damage of the myelin sheath that protects nerve fibers, resulting in a range of physical and cognitive symptoms) , dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities) and cognitive communication deficit (condition where cognitive impairments disrupts a person's ability to communicate effectively, despite intact language and speech ability). Review of Section C: Cognitive Patterns indicated Resident CR1 had a BIMS score of 3, severe impairment. Review of nurse clinical progress note dated 12/23/25, at 6:34 a.m., revealed while staff members were doing am (morning) rounds with other residents, second floor staff brought resident (CR1) to the unit and that resident (CR1) was on their unit looking for breakfast, second floor staff notified supervisor, resident denies pain/discomfort, no complaints, RLE (right lower extremity) wander guard monitor still in place. Nurse aide monitoring resident (CR1) by her room, and nurse aide re-directing resident, resident cooperative with redirection, safety maintained. Review of documentation submitted by the facility to the State Survey Agency failed to include a report of elopement for Resident CR1, referencing incident date of 12/23/25. During an interview on 4/22/26, at 1:55 p.m., Resident Nurse Assessment Coordinator (RNAC) Employee E1, former Director of Nursing (DON) in 12/2025, revealed that she was unaware of Resident CR1 being found on the second floor on 12/23/25, and only became aware of incident on 4/22/26, further stating that if she was aware of the incident, it would have been reported. During an interview on 4/22/26, at 3:15 p.m., with the Nursing Home Administrator (NHA) and DON, information was disseminated that the facility failed to implement policies and procedures to report an incident of neglect for one of three residents (Closed Record Resident CR1). 28. Pa Code 201.14(a) (c) Responsibility of licensee.28. Pa Code 201.18(b)(1)(e)(1) Management.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review and staff interview, it was determined that the facility failed to initiate a thorough investigation for incident of elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one of three residents reviewed (Closed Record CR1). Findings include: Review of facility policy Abuse - Resident and Reasonable Suspicion of a Crime, dated 1/2/25, indicated that the facility is to treat every residents with consideration, respect and full recognition of his/her dignity and individuality. This policy is part of the centers overall prevention of abuse, neglect, exploitation of residents, and misappropriation of resident property program. Purpose to provide direction to staff regarding procedures required to protect residents from abuse, to respond appropriately to allegations, to satisfy reporting and notification obligations, and to conduct investigations.Definitions:Neglect - the failure of the facility, the staff, or service provider 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.Abuse or neglect of residents will not be tolerated, and any suspected occurrence will be investigated promptly and with discretion. Alleged violations, whether or not confirmed, must be reported to the Administrator, PA Department of Health (DOH), the Area Agency on Aging, Compliance Officer, and to the Executive Director, and a full investigation conducted. Review of facility policy Wanderguard and Elopement Policy, dated 1/2/25, indicated it is the policy of the facility to implement safety measures for resident who wander and/or are at risk for elopement to attempt to prevent elopement.Definitions:Wandering - random or repetitive locomotion. This may be movement may be goal-directed or may be non-goal-directed or aimless. Non-goal-directed wandering requires a response in a manner that addresses both safety issues and an evaluation to identify root causes to the degree possible.Elopement - when a resident leaves the premises or safe area without the facilities knowledge and supervision. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2025, indicated that a Brief Interview for Mental Status (BIMS), is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of the clinical record indicated Resident CR1 was originally admitted to the facility on [DATE]; was discharged to another facility 3/18/26. Review of the Resident CR1's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 12/3/25, included diagnoses of multiple sclerosis (autoimmune disease that affects the central nervous system, leading to damage of the myelin sheath that protects nerve fibers, resulting in a range of physical and cognitive symptoms) , dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities) and cognitive communication deficit (condition where cognitive impairments disrupts a person's ability to communicate effectively, despite intact language and speech ability). Review of Section C: Cognitive Patterns indicated Resident CR1 had a BIMS score of 3, severe impairment. Review of Section E: Behavior indicated Resident CR1 had not exhibited wandering behavior. Review of Section P: Restraints and Alarms indicated wander/elopement alarm was used daily. Review of physician order dated 5/16/25, indicated to check function of wander guard (a safety system designed to prevent at-risk residents, such as those with dementia, from leaving a care facility unsupervised, using wearable devices and door monitoring technology) daily on 11-7, Special instruction: Function check once a day 11:00 p.m. - 7:00 a.m. Review of physician order dated 7/9/25, indicated wander guard AAT's (at all times) check placement and documents every shift, Special instructions: 827066 (wander guard ID number) every shift, days, eve, nights. Review of physician order dated 6/24/25, indicated (Resident CR1) - may move about the floor without supervision but may not exit the unit/safe area without supervision. Review of physician order dated 6/10/24, indicated ADL (Activities of Daily Living) - Ambulation: Assist x1/Supervision for 300 feet without wheeled walker, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	every shift days, eve, nights. Review of physician clinical progress note dated 12/9/25,at 7:15 p.m., indicated seeing her (Resident CR1) today for staff reporting possible UTI (urinary tract infection) due to AMS (altered mental status) and wandering. Review of nurse clinical progress note dated 12/23/25, at 6:34 a.m., revealed while staff members were doing am (morning) rounds with other residents, second floor staff brought resident (CR1) to the unit and that resident (CR1) was on their unit looking for breakfast, second floor staff notified supervisor, resident denies pain/discomfort, no complaints, RLE (right lower extremity) wander guard monitor still in place. Nurse aide monitoring resident (CR1) by her room, and nurse aide re-directing resident, resident cooperative with redirection, safety maintained. Review of documentation submitted by the facility to the State Survey Agency failed to include a report of investigating an elopement for Resident CR1, referencing incident date of 12/23/25. During an interview on 4/22/26, at 1:55 p.m., Resident Nurse Assessment Coordinator (RNAC) Employee E1, former Director of Nursing (DON) in 12/2025, revealed that she was unaware of Resident CR1 being found on the second floor on 12/23/25, and only became aware of incident on 4/22/26, further stating that if she was aware of the incident, it would have been investigated. During an interview on 4/22/26, at 3:15 p.m.,- with the Nursing Home Administrator (NHA) and DON, information was disseminated that the facility failed to initiate a thorough investigation for an incident of elopement for Resident CR1. 28 Pa. Code: 201.14 (a) Responsibility of licensee.28 Pa. Code: 201.18 (b)(1)(e)(1) Management.28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing services.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interview, it was determined that the facility failed to ensure Minimum Data Set (MDS - a periodic assessment of care needs) assessments accurately reflected the resident's status for one of three residents (Closed Record Resident CR1).Findings include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated the following instructions:Review the resident's medical record (e.g., physician orders, nurses' notes, nursing assistant documentation) to determine if alarms were used during the 7-day look-back period.After determining whether or not an item was used during the 7-day look-back period, code the frequency of use: Code 0, not used: if the device was not used during the 7-day look-back period. Code 1, used less than daily: if the device was used less than daily. Code 2, used daily: if the device was used on a daily basis during the look-back period. Review of facility policy Assessment - MDS/RAI and Care Planning, dated 1/2/25, indicated the it is the policy of the facility to comply with federal and state regulatory requirements related to MDS and RAI Manual, incorporate physician orders, medication administration records, treatment administration records, practioner progress notes which include treatment plans, and skilled therapy treatment plans as part of the whole resident care plan. Review of the clinical record indicated Resident CR1 was originally admitted to the facility on [DATE]; was discharged to another facility 3/18/26. Review of the Resident CR1's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 3/5/26, included diagnoses of multiple sclerosis (autoimmune disease that affects the central nervous system, leading to damage of the myelin sheath that protects nerve fibers, resulting in a range of physical and cognitive symptoms) , dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities) and cognitive communication deficit (condition where cognitive impairments disrupts a person's ability to communicate effectively, despite intact language and speech ability). Review of Section P: Restraints and Alarms indicated wander/elopement alarm was coded 0, indicating the device was not used during the look-back period. Review of physician order dated 5/16/25, indicated to check function of wander guard (a safety system designed to prevent at-risk residents, such as those with dementia, from leaving a care facility unsupervised, using wearable devices and door monitoring technology) daily on 11-7, Special instruction: Function check once a day 11:00 p.m. - 7:00 a.m. Review of physician order dated 7/9/25, indicated wander guard AAT's (at all times) check placement and documents every shift, Special instructions: 827066 (wander guard ID number) every shift, days, eve, nights. Review of Resident CR1's medication administration record dated 2/19/26, through 3/18/26, indicated that a wander/elopement alarm was used daily during this time frame.Review of Resident CR1's current plan of care, initiated 12/4/25, indicated potential for elopement, with intervention for wander guard at all times, check function/placement every shift. During an interview on 4/22/26, at 1:57 p.m., Resident Nurse Assessment Coordinator (RNAC) Employee E1 confirmed the facility failed to ensure Minimum Data Set assessments accurately reflected the resident's status for Resident CR1. 28 Pa. Code 211.12(c)(d)(5) Nursing services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview, it was determined the facility failed to make certain a resident had an updated, person-centered care plan individualized to each specific resident's needs after an incident of elopement for one of three residents (Closed Record Resident CR1).Finding include: Review of facility policy Wanderguard and Elopement Policy, dated 1/2/25, indicated it is the policy of the facility to implement safety measures for resident who wander and/or are at risk for elopement to attempt to prevent elopement.Definitions:Wandering - random or repetitive locomotion. This may be movement may be goal-directed or may be non-goal-directed or aimless. Non-goal-directed wandering requires a response in a manner that addresses both safety issues and an evaluation to identify root causes to the degree possible.Elopement - when a resident leaves the premises or safe area without the facilities knowledge and supervision. Review of facility policy Assessment - MDS/RAI and Care Planning, dated 1/2/25, indicated the it is the policy of the facility to comply with federal and state regulatory requirements related to MDS and RAI Manual, incorporate physician orders, medication administration records, treatment administration records, practioner progress notes which include treatment plans, and skilled therapy treatment plans as part of the whole resident care plan. Review of facility policy Assessment - Comprehensive Person-Centered Care Planning dated 1/2/25, indicated it is the policy of the facility to comply with requirements related to comprehensive person-centered care p[planning. The service provided to or arranged for residents meets professional standards of quality, are provided by qualified persons, and are culturally-competent and trauma-informed. The interdisciplinary team develops reviews, revises and implements a comprehensive person-centered care plan for each resident, consistent with resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2025, indicated that a Brief Interview for Mental Status (BIMS), is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of the clinical record indicated Resident CR1 was originally admitted to the facility on [DATE]; was discharged to another facility 3/18/26. Review of the Resident CR1's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 12/3/25, included diagnoses of multiple sclerosis (autoimmune disease that affects the central nervous system, leading to damage of the myelin sheath that protects nerve fibers, resulting in a range of physical and cognitive symptoms) , dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities) and cognitive communication deficit (condition where cognitive impairments disrupts a person's ability to communicate effectively, despite intact language and speech ability). Review of Section C: Cognitive Patterns indicated Resident CR1 had a BIMS score of 3, severe impairment. Review of Section E: Behavior indicated Resident CR1 had not exhibited wandering behavior. Review of Section P: Restraints and Alarms indicated wander/elopement alarm was used daily. Review of physician order dated 7/9/25, indicated wander guard AAT's (at all times) check placement and documents every shift, Special instructions: 827066 (wander guard ID number) every shift, days, eve, nights. Review of physician order dated 6/24/25, indicated (Resident CR1) - may move about the floor without supervision but may not exit the unit/safe area without supervision. Review of physician clinical progress note dated 12/9/25,at 7:15 p.m., indicated seeing her (Resident CR1) today for staff reporting possible UTI (urinary tract infection) due to AMS (altered mental status) and wandering. Review of nurse clinical progress note dated 12/23/25, at 6:34 a.m., revealed while staff members were doing am (morning) rounds with other residents, second floor staff brought resident (CR1) to the (continued on next page)

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	04/22/2026

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.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unit and that resident (CR1) was on their unit looking for breakfast, second floor staff notified supervisor, resident denies pain/discomfort, no complaints, RLE (right lower extremity) wander guard monitor still in place. Nurse aide monitoring resident (CR1) by her room, and nurse aide re-directing resident, resident cooperative with redirection, safety maintained. Review of Resident CR1's elopement care plan, initiated 12/4/25, failed to indicate update or revision of goals and interventions after an incident of elopement on 12/23/25. During an interview on 4/22/26, at 1:54 p.m., Resident Nurse Assessment Coordinator (RNAC) Employee E1, former Director of Nursing (DON) in 12/2025, revealed that she was unaware of Resident CR1 being found on the second floor on 12/23/25, and only became aware of event on 4/22/26, and confirmed that the facility failed to make certain Resident CR1 had an updated, person-centered care plan individualized to meet specific needs after an incident of elopement. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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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 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** Based on facility policy review, clinical and facility record review, facility submitted documents, and staff interviews, it was determined that the facility failed to provide adequate supervision to prevent elopement for one of four residents (Closed Record Resident CR1). This was identified as past non-compliance.Findings include: Review of facility policy Wanderguard and Elopement Policy, dated 1/2/26, indicated it is the policy of the facility to implement safety measures for resident who wander and/or are at risk for elopement to attempt to prevent elopement.Definitions:Wandering - random or repetitive locomotion. This may be movement may be goal-directed or may be non-goal-directed or aimless. Non-goal-directed wandering requires a response in a manner that addresses both safety issues and an evaluation to identify root causes to the degree possible.Elopement - when a resident leaves the premises or safe area without the facilities knowledge and supervision. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2025, indicated that a Brief Interview for Mental Status (BIMS), is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of the clinical record indicated Resident CR1 was originally admitted to the facility on [DATE]; was discharged to another facility 3/18/26. Review of the Resident CR1's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 3/5/26, included diagnoses of multiple sclerosis (autoimmune disease that affects the central nervous system, leading to damage of the myelin sheath that protects nerve fibers, resulting in a range of physical and cognitive symptoms) , dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities) and cognitive communication deficit (condition where cognitive impairments disrupts a person's ability to communicate effectively, despite intact language and speech ability). Review of Section C: Cognitive Patterns indicated Resident CR1 had a BIMS score of 3, severe impairment. Review of Section E: Behavior indicated Resident CR1 had not exhibited wandering behavior. Review of Section P: Restraints and Alarms indicated wander/elopement alarm was not used. Review of physician order dated 5/16/25, indicated to check function of wander guard (a safety system designed to prevent at-risk residents, such as those with dementia, from leaving a care facility unsupervised, using wearable devices and door monitoring technology) daily on 11-7, Special instruction: Function check once a day 11:00 p.m. - 7:00 a.m. Review of physician order dated 7/9/25, indicated wander guard AAT's (at all times) check placement and documents every shift, Special instructions: 827066 (wander guard ID number) every shift, days, eve, nights. Review of Resident CR1's medication administration record dated 2/19/26, through 3/18/26, indicated that a wander/elopement alarm was used daily during this time frame. Review of Elopement Evaluation dated 2/13/26, indicated the following:Is resident ambulatory or independent in wheelchair locomotion? YesDoes the resident have any of the following risk factors? No Elopement risk factors identified or verbalized.Resident is at minimal risk for elopement; Elopement care plan not needed at this time.Additional information: Resident made not further statements about leaving tonight, she does have a wander guard on. She did not leave her room tonight. Review of clinical progress note dated 3/17/26, at 12:35 p.m., recorded as a late entry on 3/18/26, at 7:36 a.m., revealed Resident CR1 got onto the elevator and was found on the first floor. She was escorted back to the unit without incident. Review of clinical progress note dated 3/18/26, at 2:20 p.m., indicated driver arrived to facility and took resident (CR1) and all her belongings to (sister facility). Review of clinical progress note dated 3/18/26, at 2:41 p.m., indicated Admissions spoke with Resident CR1's niece for authorization to transfer resident to secure unit related to elopement risk. Niece okay with transfer. Review of facility submitted information dated 4/2/26, indicated that on 3/17/26, it was reported to the Administrator that Resident CR1 entered the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	elevators on the 3rd floor went to the 1st floor in the elevators and never exited elevator without supervision. Resident CR1 is care planned for supervision off the 3rd floor. Resident CR1 was an elopement risk due to her wandering. Resident CR1 wears a wander guard. Resident CR1 left her room at 12:02 p.m., entered elevator at 12:03 p.m., and the elevator doors open at 12:05 p.m. on the 1st floor. Staff last saw her at 12:02 p.m. as she left her room. Staff were at elevator floors on the 1st floor and staff escorted Resident CR1back to her room. Resident is currently receiving physical therapy and salon services on the 1st floor; she told staff that she had an appointment that she was going to. Elevators are now programmed to require a code to go to the first door. MD and next of kin notified. Resident CR1 transferred to a secure memory unit with MD and next of kin consent. Review of employee statement written by Director of Nursing (DON) Secretary Employee E2, dated 3/17/26, indicated (Employee E2) saw the resident (Resident CR1) exiting the elevator on the 1st floor by herself around noon. (Employee E)2 asked her (Resident CR1) if she was going see therapy or the beautician. She (Resident CR1) replied that she had an appointment, but could not recall who the appointment was with. (Employee E2) called the nursing supervisor to ask if she knew if resident (CR1) had any appointment todays. Nursing supervisor then asked unit clerk and she responded with No she did not. (EVS Manager Employee E3) and (Employee E2) waited with the resident (CR1) until the aide got down to the 1st floor to escort the resident (CR1) back to the unit. Review of employee statement written by EVS Manager Employee E3, dated 3/17/26, indicated while waiting for the elevators on the floor #1, a resident (CR1) came out of the elevator, confused, and lost. (Employee E3) and (Employee E2) called for help from nursing. Nursing and social service assisted the resident (CR1) back to her room. On 3/17/26, the facility initiated a plan of correction that included:Returning Resident CR1 to unit/room safely ensuring no further incidents.MD and next of kin were notified of event and permission given to transfer to secure unit. Resident CR1 was transferred to secure unit at sister facility 3/18/26.Resident directly involved in this deficient practice had their care plans reviewed and updated by the DON or designee and updated to reflect current wandering and elopement risk.The MDS Coordinator reviewed Section E of the MDS and associated CAA's for all residents. Care plans were reviewed and updated to ensure they reflect audit findings. Concerns were/were not identified. All facility staff on all shifts received education on wandering, elopement, and resident safety from the DON or designee(s). Any staff on leave will receive education on their next scheduled workday.Elopement and wandering residents'' policy was reviewed/revised. Ad Hoc QAPI Committee meeting took place 3/17/26, regarding elopement earlier in day. The facility revised its pre-admission screening intake form to include a question about history or frequency of wandering and elopement. The DON or designee will audit new admission for elopement risk and ensure appropriate interventions are in place. The DON or designee will audit completed MDS's to ensure the care plan reflects needs/concerns identified in the CAAs. New hires will receive education on wandering, elopement, and resident safety by the DON, Director of Social Services, or designee. A Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP) was implemented to review and interpret all audit findings. All findings will be discussed at the monthly QAA meeting for a minimum of three months or until the pattern of compliance is maintained. Elevators updated to require a code to go to the 1st floor as of 3/18/26. The facility was back in compliance on 3/19/26. Interviews with five licensed nursing staff, three nursing assistants, and eleven ancillary staff on 4/22/26, confirmed they received education on wandering, elopement, and resident safety procedures according to facility policy. All staff interviewed acknowledged understanding of facility policy. During an interview on 4/22/26, at 3:15 p.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility failed to provide adequate supervision to prevent elopement for one of three residents (Resident CR1), that was determined to be past noncompliance. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1)(e)(1) Management.28 Pa. Code 201.29(a) Resident rights.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa Code 211.12(d)(1)(2)(5) Nursing services.