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 06/28/2024

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 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** 46167 Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to implement written policies and procedures to ensure a complete and thorough investigation of an incident involving the potential for neglect for one of three residents (Resident R52) involving a choking incident. Findings include: Review of facility policy Abuse - Resident and Reasonable Suspicion of a Crime dated 1/3/24, indicated neglect is 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. Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person. The House Supervisor or Administrator/Designee interviews and obtains written statements from complaining party and witnesses using a facility form. Review of the clinical record indicated Resident R52 was admitted to the facility on [DATE]. Review of Resident R52's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/29/24, indicated diagnoses of dementia (a group of symptoms that affects memory, thinking, and interferes with daily life), unspecified intellectual disabilities, and dysphagia (difficulty swallowing). Review of Resident R52's care plan dated 3/27/23, indicated Resident R52 places non-food items in her mouth due to having [NAME] (an eating disorder characterized by a tendency to eat substances that provide no nutritive value such as soil, chalk, hair, paper, etc.). Goals included Resident R52 will not choke or aspirate on non-food items. Review of a facility event submitted to the State dated 5/20/24, indicated, Social Worker alerted nurses at the nurses station that Resident R52 was on the floor bleeding from laceration (a deep cut or tear in skin) to forehead, upon assessment she began vomiting clear brown fluid with strong smell of tobacco and 3-5 pouches of chewing tobacco and paper towel. Resident has a history of Pica. Administrator, Direct of Nursing, and Social Work Supervisor met with Resident R112 the following day and explained we could no longer accommodate his chewing habit as he clearly put another resident at risk for injury. All tobacco products were removed from him, his family was contacted and in agreement with the termination of his chewing habit. (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: 395606	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024
NAME OF PROVIDER OR SUPPLIER John J Kane Regional Center-Ro		STREET ADDRESS, CITY, STATE, ZIP CODE 110 McIntyre Road Pittsburgh, PA 15237	

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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	Review of a nursing progress note dated 5/20/24, completed by Registered Nurse (RN) Employee E8 stated, Alerted by staff that resident was in a fetal position in the hallway near the nurses station at 10:30 a.m. Resident had fallen out of the wheelchair, upon assessment resident was noted to be bleeding from a laceration on her forehead and cyanotic (bluish skin due to lack of oxygen) in the face. The charge nurse repositioned the resident and she began to vomit, at first it was just clear vomit with brown specks in it. She then proceeded to vomit chewing tobacco pouches which were whole in size and smelled of the tobacco. There was 5 pouches in total. She also vomited a paper towel and some clear/brown vomit. Immediately after vomiting her color returned and resident was placed in her chair, the laceration was irrigated. Review of dictated security footage dated 5/20/24, indicated the following timeline: - 9:36:26: Resident R112 returns to dining room and to his table, gathers his items, goes over to his corner, puts all of his items up on another table including his chew cup. - 9:45:33: Resident R112 backs up and out of his table and down further to another table. He has his items and chew cup. - 10:00:47: Resident R52 starts down hall towards dining hall. - 10:25:27: Resident R52 enters/exits dining hall, goes to nurses station then Resident R112 goes down towards fridge. - 10:32:10: Resident R52 re-enters. - 10:33:33: Resident R52 goes over to Resident R112's chew cup, puts the contents in her mouth at 10:33:35, goes past Resident R122, stay in dining hall till 10:36:28. - 10:36:28: Resident R52 exits dining room and stops in front of recreation office. - 10:36:53: Resident R52 leaves recreation office and goes towards nursing station. Housekeeping is buffing hallway. - 10:37:14: As Resident R52 goes past Nurse Aide (NA) Employee E3, NA Employee E3 puts on a glove and looks to take something from Resident R52. NA Employee E3 continues on transporting another resident. - 10:37:47: Resident R52 stops short of the nursing station. - 10:38:10: Social Services employee gets key to the ladies room, walks in front of Resident R52. - 10:38:37: You can see Resident R52's right arm starting to move, she appears to be moving forward. - 10:38:45: Resident R52 falls forward landing on her right side. - 10:38:45: No one is aware that Resident R52 fell . (continued on next page)

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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	- 10:39:08: Social Services leaves restroom, calls attention to the fall. - 10:39:14 Licensed Practical Nurse (LPN) E5 responds. Review of a witness statement completed by LPN Employee E5, dated 5/20/24, stated, I was called over by Social Worker that resident was on the floor. When I got to her she was face down on the floor curled in a slight ball. Face was blue in color. She was also bleeding from a bump on her forehead. She began to vomit and cough. Large pieces of paper towel and tobacco sacks came up in vomit. Review of the facility's investigation documentation failed to include a witness statement obtained from NA Employee E3. On 6/27/24, at 10:37 a.m. the State Agency reached out to NA Employee E3 for a statement. NA Employee E3 did not return a phone call to the State Agency. During an interview on 6/26/24, at 12:18 p.m. the Director of Nursing (DON) stated, I'm not sure what NA Employee E3 took from Resident R52. I did not perform this investigation because I was on vacation. If it's not with this investigation, I have to assume a statement was not obtained from NA Employee E3. During an interview on 6/26/24, at 12:18 p.m. the DON confirmed that the failed to implement written policies and procedures to ensure a complete and thorough investigation of an incident involving the potential for neglect for one of three residents (Resident R52). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management.

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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 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** 48546 Based on review of facility documents, facility policy, clinical records, and staff interview, it was determined that the facility failed to conduct a thorough investigation of a choking incident to rule out neglect for one of three residents (Resident R52). Findings include: Review of facility policy Abuse - Resident and Reasonable Suspicion of a Crime dated 1/3/24, indicated neglect is 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. Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person. The House Supervisor or Administrator/Designee interviews and obtains written statements from complaining party and witnesses using a facility form. Review of the clinical record indicated Resident R52 was admitted to the facility on [DATE]. Review of Resident R52's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/29/24, indicated diagnoses of dementia (a group of symptoms that affects memory, thinking, and interferes with daily life), unspecified intellectual disabilities, and dysphagia (difficulty swallowing). Review of Resident R52's care plan dated 3/27/23, indicated Resident R52 places non-food items in her mouth due to having [NAME] (an eating disorder characterized by a tendency to eat substances that provide no nutritive value such as soil, chalk, hair, paper, etc.). Goals included Resident R52 will not choke or aspirate on non-food items. Review of a facility event submitted to the State dated 5/20/24, indicated, Social Worker alerted nurses at the nurses station that Resident R52 was on the floor bleeding from laceration (a deep cut or tear in skin) to forehead, upon assessment she began vomiting clear brown fluid with strong smell of tobacco and 3-5 pouches of chewing tobacco and paper towel. Resident has a history of Pica. Administrator, Direct of Nursing, and Social Work Supervisor met with Resident R112 the following day and explained we could no longer accommodate his chewing habit as he clearly put another resident at risk for injury. All tobacco products were removed from him, his family was contacted and in agreement with the termination of his chewing habit. Review of a nursing progress note dated 5/20/24, completed by Registered Nurse (RN) Employee E8 stated, Alerted by staff that resident was in a fetal position in the hallway near the nurses station at 10:30 a.m. Resident had fallen out of the wheelchair, upon assessment resident was noted to be bleeding from a laceration on her forehead and cyanotic (bluish skin due to lack of oxygen) in the face. The charge nurse repositioned the resident and she began to vomit, at first it was just clear vomit with brown specks in it. She then proceeded to vomit chewing tobacco pouches which were whole in size and smelled of the tobacco. There was 5 pouches in total. She also vomited a paper towel and some clear/brown vomit. Immediately after vomiting her color returned and resident was placed in her chair, the laceration was irrigated. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of dictated security footage dated 5/20/24, indicated the following timeline: - 9:36:26: Resident R112 returns to dining room and to his table, gathers his items, goes over to his corner, puts all of his items up on another table including his chew cup. - 9:45:33: Resident R112 backs up and out of his table and down further to another table. He has his items and chew cup. - 10:00:47: Resident R52 starts down hall towards dining hall. - 10:25:27: Resident R52 enters/exits dining hall, goes to nurses station then Resident R112 goes down towards fridge. - 10:32:10: Resident R52 re-enters. - 10:33:33: Resident R52 goes over to Resident R112's chew cup, puts the contents in her mouth at 10:33:35, goes past Resident R122, stay in dining hall till 10:36:28. - 10:36:28: Resident R52 exits dining room and stops in front of recreation office. - 10:36:53: Resident R52 leaves recreation office and goes towards nursing station. Housekeeping is buffing hallway. - 10:37:14: As Resident R52 goes past Nurse Aide (NA) Employee E3, NA Employee E3 puts on a glove and looks to take something from Resident R52. NA Employee E3 continues on transporting another resident. - 10:37:47: Resident R52 stops short of the nursing station. - 10:38:10: Social Services employee gets key to the ladies room, walks in front of Resident R52. - 10:38:37: You can see Resident R52's right arm starting to move, she appears to be moving forward. - 10:38:45: Resident R52 falls forward landing on her right side. - 10:38:45: No one is aware that Resident R52 fell . - 10:39:08: Social Services leaves restroom, calls attention to the fall. - 10:39:14 Licensed Practical Nurse (LPN) E5 responds. Review of a witness statement completed by LPN Employee E5, dated 5/20/24, stated, I was called over by Social Worker that resident was on the floor. When I got to her she was face down on the floor curled in a slight ball. Face was blue in color. She was also bleeding from a bump on her forehead. She began to vomit and cough. Large pieces of paper towel and tobacco sacks came up in vomit. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation documentation failed to include a witness statement obtained from NA Employee E3. On 6/27/24, at 10:37 a.m. the State Agency reached out to NA Employee E3 for a statement. NA Employee E3 did not return a phone call to the State Agency. During an interview on 6/26/24, at 12:18 p.m. the Director of Nursing (DON) stated, I'm not sure what NA Employee E3 took from Resident R52. I did not perform this investigation because I was on vacation. If it's not with this investigation, I have to assume a statement was not obtained from NA Employee E3. During an interview on 6/26/24, at 12:18 p.m. the DON confirmed that the facility failed to conduct a thorough investigation of a choking incident to rule out neglect for one of three residents (Resident R52). 28 Pa Code: 201.18 (e)(1)(2) Management 28 Pa Code: 201.29 (a)(c)(d) Resident Rights 28 Pa Code: 211.12 (a)(c)(d)(1)(3)(5) Nursing services

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for four out of four residents sampled with facility-initiated transfers (Residents R2, R41, R81, and R118). Findings include: Review of facility policy Transfer of Resident to Acute Facility dated 1/3/24, indicated the nurse documents in the electronic medical record notification of practitioner, notification of resident representative, and preparation of resident. The nurse sends the following information to the receiving facility: contact information of the practitioner responsible for the care of the resident, contact information for the resident representative, advance directive, all special instructions or precautions for ongoing care, comprehensive care plan goals, all other necessary information including but not limited to residents' overall status, discharge summary, diagnosis, allergies, medications, and recent lab or diagnostic studies. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/21/24, indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), hypertension (high blood pressure in the arteries), and anemia (too little iron in the body causing fatigue). Review of the clinical record indicated Resident R2 was transferred to the hospital on 9/29/23 and returned to the facility on [DATE]. Review of Resident R2's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R41 was admitted to the facility on [DATE]. Review of Resident 41's MDS dated [DATE], indicated diagnoses of heart failure, hypertension, and depression. Review of the clinical record indicated Resident R41 was transferred to the hospital on 1/13/24 and returned to the facility on [DATE]. (continued on next page)

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R41's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R81 was admitted to the facility on [DATE]. Review of Resident R81's MDS dated [DATE], indicated diagnoses of high blood pressure, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and muscle wasting. Review of the clinical record indicated Resident R81 was transferred to the hospital on 12/31/23 and returned to the facility on [DATE]. Review of Resident R81's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R118 was admitted to the facility on [DATE]. Review of Resident R118's MDS dated [DATE], indicated diagnoses of quadriplegia (paralysis of all four limbs), bipolar disorder (a mental condition marked by alternating periods of elation and depression), and neck pain. Review of the clinical record indicated Resident R81 was transferred to the hospital on 4/3/24. Review of Resident R118's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. During an interview on 6/25/24, at 2:42 p.m. the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for four out of four residents sampled with facility-initiated transfers (Residents R2, R41, R81, and R118). 28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for three of four residents (Resident R2, R41, and R81). Findings include: Review of Title 42 Code of Federal Regulations S483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged ; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and [NAME] of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/21/24, indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), hypertension (high blood pressure in the arteries), and anemia (too little iron in the body causing fatigue). Review of the clinical record indicated Resident R2 was transferred to the hospital on 9/29/23 and returned to the facility on [DATE]. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R2's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE]. Review of the clinical record indicated Resident R41 was admitted to the facility on [DATE]. Review of Resident 41's MDS dated [DATE], indicated diagnoses of heart failure, hypertension, and depression. Review of the clinical record indicated Resident R41 was transferred to the hospital on 1/13/24 and returned to the facility on [DATE]. Review of Resident R41's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE]. Review of the clinical record indicated Resident R81 was admitted to the facility on [DATE]. Review of Resident R81's MDS dated [DATE], indicated diagnoses of high blood pressure, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and muscle wasting. Review of the clinical record indicated Resident R81 was transferred to the hospital on 12/31/23 and returned to the facility on [DATE]. Review of Resident R81's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE]. During an interview on 6/26/24, at 2:15 p.m. the Social Services Employee E11 confirmed that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for three of four residents (Resident R2, R41, and R81). 28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for four of four resident hospital transfers (Resident R2, R41, R81, and R118). Findings Include: Review of facility policy Bed Hold Notice and Procedures dated 1/3/24, indicated written notice of the bed hold policy will be provided to the resident or legal representative upon admission, upon hospital transfer, or at day two or three when resident is admitted to the hospital, and upon therapeutic leave of absences lasting over 24 hours. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/21/24, indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), hypertension (high blood pressure in the arteries), and anemia (too little iron in the body causing fatigue). Review of the clinical record indicated Resident R2 was transferred to the hospital on 9/29/23 and returned to the facility on [DATE]. Review of Resident R2's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 9/29/23. Review of the clinical record indicated Resident R41 was admitted to the facility on [DATE]. Review of Resident 41's MDS dated [DATE], indicated diagnoses of heart failure, hypertension, and depression. Review of the clinical record indicated Resident R41 was transferred to the hospital on 1/13/24 and returned to the facility on [DATE]. Review of Resident 41's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 1/13/24. Review of the clinical record indicated Resident R81 was admitted to the facility on [DATE]. Review of Resident R81's MDS dated [DATE], indicated diagnoses of high blood pressure, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and muscle wasting. (continued on next page)

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record indicated Resident R81 was transferred to the hospital on 12/31/23 and returned to the facility on [DATE]. Review of Resident R81's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 12/31/23. Review of the clinical record indicated Resident R118 was admitted to the facility on [DATE]. Review of Resident R118's MDS dated [DATE], indicated diagnoses of quadriplegia (paralysis of all four limbs), bipolar disorder (mental condition marked by alternating periods of elation and depression), and neck pain. Review of the clinical record indicated Resident R118 was transferred to the hospital on 4/3/24. Review of Resident R118's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 4/3/24. During an interview on 6/25/24, at 2:41 p.m. the Director of Nursing confirmed that the facility failed to notify the resident or resident's representative of the facility bed-hold policy for four of four resident hospital transfers (Resident R2, R41, R81, and R118). 28 Pa. Code: 201.29(b)(d)(j) Resident rights.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of clinical record review, and staff interview, it was determined that the facility failed to ensure that a resident and a resident's representative was provided a summary of their completed baseline care plan for three of six residents (Resident R41, R71, and R82). Findings include: Review of Resident R41's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R41's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 3/9/24, indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), hypertension (high blood pressure in the arteries), and depression. Review of Resident R41's clinical record failed to produce documentation that a resident and resident representative was provided with a summary of the baseline care plan. Review of Resident R71's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R71's MDS dated [DATE], indicated diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), and seizure disorder (a disorder in which nerve cell activity in the brain is disturbed). Review of Resident R71's clinical record failed to produce documentation that a resident and resident representative was provided with a summary of the baseline care plan. Review of Resident R82's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R82's MDS dated [DATE], indicated diagnoses of chronic kidney disease (gradual loss of kidney function), depression, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of Resident R82's clinical record failed to produce documentation that a resident and resident representative was provided with a summary of the baseline care plan. During an interview on 6/26/24, at 9:02 a.m. the MDS Coordinator Employee E16 stated, I do not give the resident or the families a copy of the baseline care plan. During an interview on 6/26/24, at 2:55 p.m. the Director of Nursing confirmed that the facility failed to ensure that a resident and a resident's representative was provided a summary of their completed baseline care plan for three of six residents (Resident R41, R71, and R82). (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code: 211.11 (a)(c)(d) Resident care plan 28 Pa. Code: 211.12(d)(1)(5) Nursing service

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to notify the physician of increased and decreased Capillary Blood Glucose (CBG) levels, failed to assess a resident for hyperglycemia (high blood glucose) and hypoglycemia (low blood glucose) for one of three residents (Resident R73), and failed to obtain physician orders for one of ten residents (Resident R369). Findings include: Review of facility Emergency Care Guidelines: Hypoglycemia Protocol dated 1/3/24, indicated a CBG reading of less than 70 milligrams per deciliter (mg/dL) and symptomatic or a CBG of less than 60 mg/dL regardless of symptoms, hold all diabetic mediations and insulin until reviewed with physician, provide treatment, recheck CBG in 15 minutes, treat according to protocol, and notify physician. May repeat such administrations of this medication up to 2 times within 30 minutes time period in the event of an acute hypoglycemic episode. The Centers for Disease Control defines diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 mg/dL. If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours, or a blood glucose greater than 180 mg/dL one to two hours after eating. If you have hyperglycemia and it's untreated for long periods of time, you can damage your nerves, blood vessels, tissues and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage and non-healing wounds. Review of facility, All Policy and Procedure General Guidelines policy dated 1/3/24, indicated that the facility will provide the necessary care and services of each resident to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. The staff must monitor the resident's status and condition and respond to significant changes promptly. Review of facility, Infection Prevention and Control Program and Plan policy dated 1/3/24, indicated that the facility will establish and maintain and infection prevention and control program to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility will determine clusters or outbreaks of infections. Interventions are implemented to prevent further transmissions of infections. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record indicated Resident R73 was admitted to the facility on [DATE]. Review of Resident R73's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/17/24, indicated diagnoses of diabetes, muscle weakness, and depression (a constant feeling of sadness and loss of interest). Review of a physician order dated 1/12/24, indicated to check Resident R73's blood glucose level before meals and at bedtime. Review of the clinical record electronic Medication Administration Record (eMAR) revealed Resident R13's CBG's were as follows: On 3/7/24, at 8:54 p.m. CBG was noted to be low On 3/12/24, at 4:02 p.m. CBG was noted to be high On 3/15/24, at 9:08 a.m. CBG was noted to be 50 On 4/2/24, at 7:06 p.m. CBG was noted to be low On 4/3/24, at 5:53 pm. CBG was noted to be 57 Review of Resident R73's clinical progress notes indicated the resident was not assessed for hyper-/hypoglycemia, facility policy was not implemented, and the physician was not notified of abnormal results on the above listed dates. During an interview on 6/28/24, at 8:47 a.m. the Director of Nursing (DON) confirmed that the facility failed to notify the physician of increased and decreased Capillary Blood Glucose levels and failed to assess a resident (Resident R73) for hyperglycemia and hypoglycemia. Review of the clinical record indicated Resident R369 was admitted to the facility on [DATE]. Review of Resident R369's MDS dated [DATE], indicated diagnoses of diabetes, chronic kidney disease (gradual loss of kidney function), and osteoarthritis (degeneration of the joint causing pain and stiffness). Review of Resident R369 ' s clinical record on 6/27/24, at 10:35 a.m. indicated that on 6/21/24 resident had three episodes of emesis and her temperature was elevated. The facility performed a Quad swab (nasal swab that can detect respiratory viruses) to rule out Influenza A and B, RSV (Respiratory syncytial virus) and COVID 19. Review of Resident R369 ' s clinical record on 6/27/24, at 10:55 a.m. failed to include a physician's order for the Quad swab. Review of Resident R369 ' s clinical record on 6/27/24, at 11:40 a.m. failed to include a physician's order for isolation (a special plan of care to keep resident away from others to prevent the spread of infection) while waiting for results of Quad swab. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/28/24, at 9:30 a.m. the Director of Nursing confirmed that the facility failed to obtain physician orders for one of ten residents (Resident R369). 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29(d) Resident Rights 28 Pa. Code 211.10 (c)(d) Resident Care policies 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services

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F 0689 Level of Harm - 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** 48546 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide adequate supervision for one of three residents (Resident R52) who had two choking episodes, which resulted in actual harm during the second choking episode that required the Heimlich maneuver (abdominal thrusts that elevate the diaphragm and increase airway pressure, forcing air from the lungs; used to expel a foreign body from the airway). Findings include: Review of facility policy Accident Prevention dated 1/3/24, indicated the interdisciplinary team (IDT) is to assess, observe, and identify environmental and resident risks/hazards. The IDT implements or revise person centered interventions to decrease the potential for accidents by evaluating previous accidents and incidents. The IDT monitors and evaluates effectiveness of interventions and modifies as needed. The IDT provides or revises training and competency as needed, identifies what triggered or contributed to the accident, identifies underlying causes and any risk factors that may have contributed to the accident, and implements interventions promptly to attempt to prevent this from happening again. Review of facility policy Assessment - Comprehensive Person-Centered Care Planning dated 1/3/24, indicated the IDT 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 clinical record indicated Resident R52 was admitted to the facility on [DATE]. Review of Resident R52's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/29/24, indicated diagnoses of dementia (a group of symptoms that affects memory, thinking, and interferes with daily life), unspecified intellectual disabilities, and dysphagia (difficulty swallowing). Review of Resident R52's care plan dated 3/27/23, indicated Resident R52 places non-food items in her mouth due to having [NAME] (an eating disorder characterized by a tendency to eat substances that provide no nutritive value such as soil, chalk, hair, paper, etc.). Goals included Resident R52 will not choke or aspirate on non-food items. Interventions included resident is eating tissues and paper towels, request made for housekeeping to remove and will lock the bathroom door. Review of Resident R52's care plan dated 4/1/23, indicated Resident R52 take food from other residents trays, putting herself at risk for choking. Goals included Resident R52 will have fewer episodes of taking food from others trays as evidenced by behavior occurring less than three times monthly. Interventions included staff to closely monitor Resident R52 during meals and that she does not take food from others trays every meal. Report to physician any choking incidents. If food is found in resident's mouth, attempt to remove it immediately. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a physician order dated 2/29/24, indicated Resident R52 was ordered a puree diet, fortified foods, liquids by cup only, no straw, puree sandwich on bread, banana, pancakes, coffee cake, donut, muffin, cheerios, soft cookies, cakes, and brownies ok. Review of information received by State dated 5/20/24, indicated, Social Worker alerted nurses at the nurses station that Resident R52 was on the floor bleeding from laceration (a deep cut or tear in skin) to forehead, upon assessment she began vomiting clear brown fluid with strong smell of tobacco and 3-5 pouches of chewing tobacco and paper towel. Resident has a history of Pica. Administrator, Direct of Nursing, and Social Work Supervisor met with Resident R112 the following day and explained we could no longer accommodate his chewing habit as he clearly put another resident at risk for injury. All tobacco products were removed from him, his family was contacted and in agreement with the termination of his chewing habit. Review of a nursing progress note dated 5/20/24, completed by Registered Nurse (RN) Employee E8 stated, Alerted by staff that resident was in a fetal position in the hallway near the nurses station at 10:30 a.m. Resident had fallen out of the wheelchair, upon assessment resident was noted to be bleeding from a laceration on her forehead and cyanotic (bluish skin due to lack of oxygen) in the face. The charge nurse repositioned the resident and she began to vomit, at first it was just clear vomit with brown specks in it. She then proceeded to vomit chewing tobacco pouches which were whole in size and smelled of the tobacco. There was 5 pouches in total. She also vomited a paper towel and some clear/brown vomit. Immediately after vomiting her color returned and resident was placed in her chair, the laceration was irrigated (cleansed). Review of a progress note dated 5/22/24, completed by Physician Assistant (PA) Employee E10 stated, The patient was initially evaluated lying on her right side of the floor. She has a small laceration to her right forehead with a hematoma (a solid swelling of clotted blood within the tissues) forming. On inspection of the right forehead laceration, it is approximately 1 centimeter (cm), irregular. She does have about two cm of surrounding swelling and bruising forming around the laceration. It appears that the patient ingested another resident's tobacco chew pouches. She was seemed to potentially choking and fell out of her wheelchair head first and hit her forehead on the floor. She vomited up three pouches that she had ingested. Staff is potentially going to contact poison control. Pica: the patient is known to do this quite frequently. She often takes a food or other items from other residents' rooms, trays, and wheelchairs and ingests them. Review of a facility event submitted to the State dated 6/18/24, indicated, Resident R52 was being assisted to her room by staff when the staff noticed her choking (her face was noted to be blue/purple). Nursing staff alerted other staff she needed assistance and nurse administered Heimlich maneuver until resident started coughing. LPN swiped residents' mouth and found several long red onions and some other unidentified food substances. Review of a progress note dated 6/18/24, completed by LPN Employee E5 stated, Called into resident's room by NA Employee E9, she came to the door and yelled she's choking. Upon entering the room, resident's face was blue/purple in color and no air was moving. I proceeded to do the Heimlich maneuver until I heard the resident start to cough. LPN Employee E12 swiped her mouth and removed several long onions and some other unidentified food substances. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a witness statement dated 6/18/24, completed by NA Employee E9 stated, I seen Resident R52 in the hallway in her wheelchair rolling pass the lunch cart. I took her back to her room to feed her and noticed once in the room she was choking. I called out for the nurses at the nursing station. LPN Employee E5 performed Heimlich and LPN Employee E12 swept her mouth to remove food. Review of a witness statement dated 6/18/24, completed by NA Employee E13 stated, On June 18, around 12:00 p.m. or 12:35 p.m. I was in the dining room. I seen a nurse running back towards another resident, I went to help the nurse with. Resident R52 was grabbing a tray off the table. A nurse and I got the tray from Resident R52, the lid was on the plate. I took Resident R52 back over to 3 East to LPN Employee E12. She was trying to get something. When I looked at her I didn't see anything in her mouth or her choking and she did not have nothing in her hands. Review of Resident R52's care plan dated 6/18/24, indicated the resident is at risk for swallowing problems related to attempting to eat others food or non-food items. Interventions included provide one to one supervision while awake and if resident is found with any food/nonfood items in her mouth besides her food, remove immediately and report to the supervisor. During an interview on 6/26/24, at 1:41 p.m. the Director of Nursing (DON) confirmed that the facility did not contact poison control after Resident R52 ingested tobacco chew pouches on 5/20/24. During an interview on 6/27/24, at 9:38 a.m. Nurse Aide (NA) Employee E4 stated, If I knew a resident had Pica, I would watch them really well and look for signs of choking. If I saw a resident eating a non-food item, I would take it away from them and notify the nurse. During an interview on 6/27/24, at 9:40 a.m. Licensed Practical Nurse (LPN) Employee E5 stated, If I knew a resident had Pica, I would make sure that items are not kept within their reach for them to grab. I would perform frequent mouth checks. If I saw a resident eating a non-food item I would remove it from their mouth and report it to my supervisor. During an interview on 6/27/24, at 9:43 a.m. LPN Employee E6 stated, If I knew a resident had Pica, I would keep non-food items out of their reach. I would expect to perform hourly rounding and I would expect the facility to educate the staff about the disorder. I would attempt to educate the resident frequently. If I saw a resident eating a non-food item, I would remove it from them, notify my supervisor, and re-educate the resident. During an interview on 6/27/24, at 9:10 a.m. Registered Dietitian Employee E7 confirmed that Resident R52 is the only resident in the facility with a [NAME] diagnosis. During an interview on 6/28/24, at 8:49 a.m. the DON confirmed that the facility did not update Resident R52's plan of care after the incident on 5/20/24. The DON stated, I made rounds on the unit and took puzzles away from the common area. Resident R52 is always under someone's feet. She hadn't gone after anything for months, then she suddenly did with the tobacco. I thought we fixed things by removing Resident R112, he had a little office set up in the dining room. I thought the incident occurred because Resident R112 was putting her at risk. No updates were made to Resident R52's plan of care after the incident on 5/20/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/28/24, at 12:06 p.m. the Nursing Home Administrator and DON confirmed that the facility failed to provide adequate supervision for a resident with [NAME] and previous choking episodes, which resulted in actual harm during the second choking episode that required the Heimlich maneuver for one of three residents (Resident R52). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 201.20(b)(1) Staff Development. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.11(d) Resident care plan.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review facility polices, observations, clinical records, and staff interviews it was determined that the facility failed to make certain that appropriate treatments and services were provided for the use of a urinary catheter as required for two of four residents (Resident R2 and R82). Findings include: Review of facility Catheter, Urinary -Bladder Irrigation: Continuous and Intermittent policy dated 1/3/24, indicated to safely provide care and treatment for bladder infections, inflammation, spasms and irritation as prescribed by the practitioner. Open solutions are discarded after twenty-four hours. Review of facility Catheter care and Drainage Bag policy dated 1/3/24, indicated to promote hygiene, monitor urinary output and minimize the growth and transmission of pathogens for residents with indwelling urinary catheters. Drainage bags are to be covered by a dignity bag. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/21/24, indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), hypertension (high blood pressure in the arteries), and anemia (too little iron in the body causing fatigue). Section H-Bladder and Bowel indicated the utilization of an indwelling catheter. Review of Resident R2's physician order dated 6/25/24, indicated to provide catheter care every shift for wound healing. During an observation on 6/25/24, at 10:45 a.m. urinary drainage bag was hanging from bed frame with no dignity bag. During an interview on 6/25/24, at 10:59 a.m. Licensed Practical Nurse, Employee E15 stated, No, I don't see one. Review of admission record indicated that Resident R82 was admitted on [DATE]. Review of Resident R82's MDS dated [DATE], indicated diagnoses diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), depression, and chronic kidney disease (gradual loss of kidney function). Section H - Bladder and Bowel indicated the utilization of an indwelling catheter. Review of Resident R82 ' s physician order dated 7/6/23, indicated to flush urinary catheter with saline water three times a day. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/24/24, at 11:00 a.m. Resident R82 was in bed with an opened piston and irrigation catheter irrigation tray (sterile water that flushes bladder) sitting on her nightstand, dated 6/22/24. During an interview on 6/24/24, at 11:08 a.m. Licensed Practical Nurse Employee E15 confirmed the irrigation tray was dated 6/22/24 and that a bladder irrigation tray should be changed daily. During an interview on 6/24/24, at 2:55 p.m., the Director of Nursing confirmed the facility failed to make certain that appropriate treatments and services were provided for the use of a urinary catheter as required for two of four residents (Resident R2 and R82). 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa code: 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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NAME OF PROVIDER OR SUPPLIER John J Kane Regional Center-Ro		STREET ADDRESS, CITY, STATE, ZIP CODE 110 McIntyre Road Pittsburgh, PA 15237	

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on facility policy review, clinical record review, observation, and staff interviews, it was determined that the facility failed to provide colostomy care and services consistent with professional standards of practice for one of three residents reviewed (Resident R41). Findings include: Review of facility policy Colostomy and Ileostomy Care dated 1/3/24, indicated residents who require special services like ostomy (a stoma is surgically created opening from an area inside the body to the outside) care receive such care consistent with professional standards of practice. Staff to notify practitioner when there are changes to the stoma or skin. Review of the admission record indicated Resident R41 was admitted to the facility on [DATE]. Review of Resident R41's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 3/29/24, indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), hypertension (high blood pressure in the arteries), and depression. Section H indicated a colostomy was present. Observation of Resident R41 on 6/24/24, at 9:45 a.m. indicated he had a colostomy. Review of Resident R41's current physician order reviewed on 6/24/24, failed to include physician orders for colostomy care, type and size of appliance or wafer, type of collection bag, and to monitor the site of the colostomy. During an interview on 6/25/24, at 12:50 p.m. Licensed Practical Nurse Employee E15 stated, no, I don't see any orders. During an interview on 6/25/24, at 1:05 p.m. the Director of Nursing confirmed the facility failed to provide colostomy care and services consistent with professional standards of practice for one of three residents reviewed (Resident R41). 28 Pa. Code: 211.11 (a)(c)(d) Resident care plan 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code:211.12(d)(1) Nursing services.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of facility policy, resident record review, and staff interviews, it was determined that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for three of three residents (Resident R83, R88, and R99). Findings include: Review of facility policy Behavior Management and Trauma Informed Care dated 1/3/24, indicated that the facility provides behavioral health care services, according to comprehensive assessment and person-centered plan of care to residents who are diagnosed with post-traumatic stress disorder (PTSD- a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). The Interdisciplinary Team will identify and address through resident/resident representative interview, triggers that can lead to expressions or indicators of distress. Review of the clinical record indicated Resident R83 was admitted to the facility on [DATE]. Review of Resident R83's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/31/24, indicated diagnoses of PTSD, high blood pressure and chronic pain. Review of Resident R83's care plan on 6/26/24, indicated that resident had PTSD, but failed to identify what the triggers were and how to avoid them. Review of the clinical record indicated Resident R88 was admitted to the facility on [DATE]. Review of Resident R88's MDS dated [DATE], indicated diagnoses of PTSD, high blood pressure and dysphagia (difficulty swallowing). Review of Resident R83's care plan on 6/26/24, indicated that resident had PTSD, but failed to identify what the triggers were and how to avoid them. Review of the clinical record indicated Resident R99 was admitted to the facility on [DATE]. Review of Resident R99's MDS dated [DATE], indicated diagnoses of PTSD, high blood pressure and muscle spasm. Review of Resident R99's care plan on 6/26/24, indicated that resident had PTSD, but failed to identify what the triggers were and how to avoid them. During an interview on 6/27/24, at 1:33 p.m., Social Worker Employee E17 confirmed that the facility failed to identify PTSD triggers for Resident R83, R88, and R99 in order to eliminate or mitigate any triggers that may cause re-traumatization for the above residents. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46167 Based on review of facility policy, observations and staff interview, it was determined the facility failed to properly date and store food products in a manner to prevent foodborne illness in the Main Kitchen. Findings include: Review of facility policy Food Storage dated 1/3/24, indicated foods products are labeled and dated with the receiving date. Never store chemicals with food and paper supplies. During an observation and interview in walk-in cooler number two in the Main Kitchen on 6/24/24, at 9:44 a. m. an opened gallon of iced tea, and an opened half- gallon container of lemonade had no date, and a plastic container of peaches, had no label or date. Food Service Director (FSD) Employee E18 confirmed that the facility failed to properly label and date opened food packages to prevent foodborne illness. During an observation and interview on 6/25/24, at 1:40 p.m. an opened bottled of iced tea was found in the chemical room in the Main Kitchen amongst the chemicals. FSD Employee E18 confirmed that the facility failed to properly segregate food and chemicals. 28 Pa. Code: 201.14(a) Responsibility of licensee 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.6(c) Dietary services.

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F 0849

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48546

Based on a review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to obtain a diagnosis for hospice services for four of four residents (Residents R70, R71, R81, and R98) and failed to have a completed hospice communication binder for one of four residents (Resident R71).

Findings include:

Review of facility policy Hospice Services dated 1/3/24, indicated any level of care above routine requires approval and authorization from the attending physician that he or she concurs that the resident's condition warrants a greater level of care. The attending physician writes an order for hospice services when resident/family agrees to hospice services and is eligible for the service.

Review of the clinical record revealed that Resident R70 was admitted to the facility on [DATE].

Review of Resident 70's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 4/14/24, indicated diagnoses of stroke, dysphagia (difficulty swallowing), and muscle wasting. Section O: Special Treatments, Procedures, and Programs indicated hospice care while a resident.

Review of a physician order dated 4/3/24, indicated to admit Resident R70 to hospice services, but did not include a diagnosis related to the need of hospice services.

Review of Resident R70's care plan dated 4/1/24, indicated she was receiving hospice services

Review of the clinical record revealed that Resident R71 was admitted to the facility on [DATE].

Review of Resident R71's MDS dated [DATE], indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), hypertension (high blood pressure in the arteries), and depression.

Review of Resident R71's physician orders dated 4/24/24, indicated to consult hospice services, but did not include an order to admit to hospice and diagnosis related to the need of hospice services.

Review of Resident R71's care plan dated 4/26/24, indicated she was receiving hospice service.

Review of Resident R71's hospice communication binder between facility and Hospice agency on 6/26/24 at 11:05 a.m. was incomplete. Communication binder did not include residents plan of care, consents, orders and the facility notification of hospice admission form was blank.

Review of the clinical record indicated Resident R81 was admitted to the facility on [DATE].

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R81's MDS dated [DATE], indicated diagnoses of high blood pressure, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and muscle wasting. Section O: Special Treatments, Procedures, and Programs indicated hospice care while a resident. Review of a physician order dated 1/9/24, indicated to admit to hospice services, but did not include a diagnosis related to the need of hospice services. Review of Resident R81's care plan dated 1/9/24, indicated she was receiving hospice services. Review of the clinical record indicated Resident R98 was admitted to the facility on [DATE]. Review of Resident R98's MDS dated [DATE], indicated diagnoses of high blood pressure, muscle wasting, and malnutrition (lack of sufficient nutrients in the body). Section O: Special Treatments, Procedures, and Programs indicated hospice care while a resident. Review of a physician order dated 5/5/23, indicated to admit to hospice services, but did not include a diagnosis related to the need of hospice services. Review of Resident R98's care plan dated 5/21/24, indicated she was receiving hospice services. During an interview on 6/26/24, at 2:55 p.m. the Nursing Home Administrator confirmed that the facility failed to obtain a diagnosis for hospice services for four of four residents (Residents R70, R71, R81, and R98) and failed to have a completed hospice communication binder for one of four residents (Resident R71). 28 Pa Code: 211.5(f)(h) Clinical records 28 Pa Code: 211.12 (d)(3)(5) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, observations, clinical record review, and staff interviews, it was determined that the facility failed to follow Enhanced Barrier Precautions (EBP) for two of four residents (Residents R1 and R65) and failed to track active infections for one out of three residents (R369). Findings include: Review of facility policy Precautions: Enhanced Barrier Precautions dated 1/3/24, indicated Enhanced Barrier Precautions are established for residents during high-contact care activities for residents with chronic wounds or indwelling medical devices. EBP is an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care. Indwelling medical devices include central lines, urinary catheters, feeding tubes, tracheostomies. High-contact resident care activities include dressing, bathing/showering, transferring when anticipating close physical contact for long duration of time, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care. Review of facility, All Policy and Procedure General Guidelines policy dated 1/3/24, indicated that the facility will provide the necessary care and services of each resident to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. The staff must monitor the resident ' s status and condition and respond to significant changes promptly. Review of facility, Infection Prevention and Control Program and Plan policy dated 1/3/24, indicated that the facility will establish and maintain and infection prevention and control program to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility will determine clusters or outbreaks of infections. Interventions are implemented to prevent further transmissions of infections. Review of the clinical record revealed that Resident R1 was admitted to the facility on [DATE]. Review of Resident 1's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 6/1/24, indicated diagnoses of paraplegia (paralysis of the legs), dysphagia (difficulty swallowing), and muscle weakness. Section H: Bladder and Bowel, indicated Resident R1 had an indwelling urinary catheter. Review of a physician's order dated 4/4/22, indicated the presence of a suprapubic catheter (a medical device that drains urine from the bladder via an incision in the abdomen) for Resident R1, related to neuromuscular dysfunction of the bladder. Review of a physician's order dated 4/3/24, inidcated that Resident R1 required Enhanced Barrier Precautions. During an observation on 6/24/24, at 11:40 a.m. a box containing personal protective equipment (PPE - isolation gowns, gloves, masks, etc.) was a present on the door of Resident R1's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/24/24, at 11:43 a.m. two employees were observed wheeling Resident R1 out if his room on a shower chair and take him into the shower room Neither employee were wearing a gown. During an interview on 6/24/24, at 11:45 a.m.one of the employees came out of the shower room and was identified as Nurse Aide (NA) Employee E14, who confirmed that she had not been wearing a gown while caring for Resident R1. When NA Employee E14 was asked why she was not wearing a gown as required, she stated she did not know that she was supposed to and also stated that she had not received education regarding Enhanced Barrier Precautions. Review of the clinical record indicated Resident R63 was admitted to the facility 5/19/24. Review of Resident R63's MDS dated [DATE], indicated diagnoses of high blood pressure, neurogenic bladder (bladder problems due to disease or injury of the nervous system involved in the control of urination), and anxiety (a feeling of worry, nervousness, or unease). Section H: Bladder and Bowel, indicated Resident R63 had an indwelling urinary catheter. Review of a physician's order dated 5/19/24, indicated the presence of an indwelling urinary catheter for neurogenic bladder. Review of a physician order dated 5/19/24, indicated Enhanced Barrier Precautions: please wear a gown and gloves for care issues. During an observation on 6/24/24, at 9:43 a.m. a sign was observed on the door of Resident R63's room stating, Gown and gloves before entering room for high-contact resident care activities. A box containing personal protective equipment (PPE - isolation gowns, gloves, masks, etc.) was also present on the door. During an observation on 6/24/24, at 9:45 a.m. Nurse Aide (NA) Employee E2 was observed providing high-contact resident care to Resident R63 and was not wearing an isolation gown. During an interview on 6/24/24, at 9:56 a.m. NA Employee E2 stated, Resident R63 is not in precautions. When asked if Resident R63 had an indwelling urinary catheter, NA Employee E2 stated, Yes she does. When asked if she observed the sign indicating gloves and a gown are needed when entering Resident R63's room, NA Employee E2 stated, That stuff is just there. No one follows that, no one wears a gown. I wear gloves and I know how to take care of a catheter. During an interview on 6/24/24, at 11:26 a.m. Infection Preventionist Employee E1 confirmed that Resident R63 is ordered enhanced barrier precautions and NA Employee E2 should have been wearing a gown and gloves while providing care to Resident R63. Review of the clinical record indicated Resident R369 was admitted to the facility on [DATE]. Review of Resident R369's MDS dated [DATE], indicated diagnoses of diabetes, chronic kidney disease (gradual loss of kidney function), and osteoarthritis (degeneration of the joint causing pain and stiffness). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R369 ' s clinical record on 6/27/24, at 10:35 a.m. indicated that on 6/21/24 resident had three episodes of emesis and her temperature was elevated. The facility performed a Quad swab (nasal swab that can detect respiratory viruses) to rule out Influenza A and B, RSV (Respiratory syncytial virus) and COVID 19. Review of Facilities Precaution List record on 6/28/24, at 9:05 a.m. failed to include Resident R369's tracking and precautions taken while waiting for results of Quad swab. During an interview on 6/24/24, at 1:25 p.m. Director of Nursing (DON) confirmed that Resident R1 is ordered enhanced barrier precautions and NA Employee E14 should have been wearing a gown while providing care to Resident R1. During an interview on 6/28/24, at 9:30 a.m. the Director of Nursing confirmed that the facility failed to track active infections for one out of three residents (R369). 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development. 28 Pa. Code: 211.10 (d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing services.