

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/18/2026
NAME OF PROVIDER OR SUPPLIER John J Kane Regional Center-Ro		STREET ADDRESS, CITY, STATE, ZIP CODE 110 McIntyre Road Pittsburgh, PA 15237	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, observation, and interviews with staff and family, it was determined that the facility failed to provide preventative interventions, and treatments which resulted in the development of avoidable pressure ulcers for two of two residents (Resident R5 and Resident R13), resulting in an infection for one of two residents (Resident R5). This failure resulted in an immediate jeopardy. Findings Include: Review of the clinical record revealed that Resident R5 was admitted to the facility on [DATE], and readmitted [DATE], with diagnoses of muscle weakness, muscle wasting and atrophy (occurs when muscle fibers shrink due to disuse, aging, malnutrition, genetic factors, or nerve-related conditions), and Parkinson's Disease (a disorder of the nervous system that affects movement and gets worse over time). Review of Resident R5's Minimum Data Set (MDS, periodic assessment of resident care needs) dated 1/20/26, indicated the diagnoses were current. Review of Section M: Skin Conditions indicated the resident was not at risk for developing pressure ulcers. It was also documented on this MDS that the resident had one unstageable (occurs when prolonged pressure, often over bony prominences such as the heels, sacrum, hips, or tailbone, causes localized tissue damage and necrosis, but the true depth of the wound is obscured by dead tissue or other coverings) pressure ulcer. Review of Resident R5's care plan initiated 8/18/25, indicated the resident remained a high risk for pressure injuries due to decreased mobility, incontinence, decrease in nutrition, and decline in overall medical condition. The care plan was revised on 12/9/25, by Registered Assessment Coordinator (RNAC), Employee E12 with interventions that included confer with physician about wound progress or lack of each week during weekly wound rounds, reduce friction and shear when moving using lift sheets, float heels off the bed, Heel medix (refers to a line of heel protectors designed to relieve pressure on vulnerable heels and prevent pressure ulcers) to both feet at all times. Review of progress note dated 12/7/25, indicated that Resident R5 was readmitted from the hospital. A deep tissue injury (DTI- a type of pressure-induced tissue damage that begins beneath the skin, often over bony prominences, and can develop into serious wounds) was observed to the resident's left heel. A further review of clinical record failed to include a skin assessment of left heel DTI upon admission which includes at a minimum, the following: (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Documentation that includes the date observed and location and staging -Size, depth and the presence, location and extent of any undermining or tunneling -Exudate, if present: type (such as purulent/serous), color, odor and approximate amount -Pain, if present: nature and frequency (e.g., whether episodic or continuous) -Wound bed including a description of color and type of tissue/character including evidence of healing (e.g., granulation tissue), or necrosis (slough or eschar); and description of wound edges and surrounding tissue. Review of Resident R5's Braden Scale Assessment (a standardized assessment tool used in healthcare to evaluate a patient's risk of developing pressure injuries/ulcer) dated 12/7/25, identified the resident to be at high risk for the development of pressure injuries. Review of Resident R5's wound assessment dated [DATE], created by Wound Care Nurse, Employee E7 revealed the resident had a left heel DTI that measured 2.5 cm x 3.5 cm. Review of Resident R5's physician order dated 12/8/25, indicated to apply cavilon (a thin, durable, waterproof coating that shields the skin from irritants such as urine, feces, wound drainage, and adhesives) daily to left heel deep tissue injury. Review of Resident R5's wound care assessment dated [DATE], completed by Certified Registered Nurse Practitioner (CRNP), Employee E8 revealed the resident was seen for a left heel deep tissue injury acquired while out to the hospital. Treatment recommendations indicated to apply Cavilon every three days and leave open to air. Review of Resident R5's physician order dated 12/10/25, indicated to apply Cavilon daily to left heel. Review of Resident R5's physician orders failed to include an order to apply Cavilon every three days and leave open to air as ordered by CRNP, Employee E8 on 12/10/25. Review of Resident R5's December Medication Administration Record (MAR) revealed the resident's left heel pressure ulcer was cleansed with betadine daily. The facility failed to apply Cavilon every three days and leave open to air as CRNP, Employee E8 ordered on 12/10/25. During an interview on 7/16/26, at 10:06 a.m. the DON stated Wound Care Nurse, Employee E7 rounds with CRNP, Employee E8 each week and is responsible for entering wound care orders into the resident's clinical record. The DON confirmed Resident R5 did not receive treatment as ordered by CRNP, Employee E8 on 12/10/25, to apply Cavilon to left heel every three days. Review of Resident R5's wound care assessment dated [DATE], completed by CRNP, Employee E8 indicated recommendations to apply skin prep (or similar protective barrier film) to bilateral heels per facility protocol as prophylactic measure. Plan of care and education discussed with facility staff. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident R5's clinical record revealed weekly wound care assessments dated 1/14/26, and 1/21/26, included, but not limited to, all of the above information from previous note dated 1/7/26. During an interview on 7/16/26, at 10:06 a.m. the DON confirmed Wound Care Nurse, Employee E7 failed to enter an order to apply skin prep (or similar protective barrier film) to Resident R5's bilateral heels as ordered by CRNP, Employee E8 on 1/7/26, 1/14/26, and 1/21/26. The DON confirmed the facility failed to implement the wound care orders as recommended by wound care CRNP, Employee E8. During an interview on 7/16/26, at 2:12 p.m. Wound Care Nurse, Employee E7 confirmed each week wound rounds are conducted with CRNP, Employee E8. Wound Care Nurse, Employee E7 indicated she keeps track of wound orders provided by CRNP, Employee E8 and inputs the orders and care planning in the resident's clinical record. Recommendations provided are entered as order. Wound care nurse, Employee E7 stated skin prep requires an order, and it must be signed off as completed in the clinical record. Wound Care Nurse, Employee E7 confirmed an order to apply skin prep (or similar protective barrier film) to Resident R5's bilateral heels was not entered prior to the development of the resident's right heel wound. Review of Resident R5's wound assessment dated [DATE], indicated the resident developed a right heel stage three pressure ulcer that was not present on admission/reentry. The pressure ulcer measured 1.2 centimeters (cm) x 1.4 cm with light bloody exudate. During an interview on 7/16/26, at 10:06 a.m. the DON confirmed Wound Care Nurse, Employee E7 failed to enter an order to apply skin prep (or similar protective barrier film) to Resident R5's bilateral heels as ordered by CRNP, Employee E8 on 1/7/26, 1/14/26, and 1/21/26. The DON confirmed the facility failed to have a preventative measure such as skin prep (or similar protective barrier film) applied to Resident R5's bilateral heels as ordered by CRNP, Employee E8 prior to the development of the resident's right heel wound. During an interview on 7/16/26, at 1:37 p.m. the DON confirmed Resident R5 failed to have a physician order to treat the right heel stage III pressure ulcer on 1/26/26, and 1/27/26. Review of Resident R5's physician orders dated 1/28/26, indicated to cleanse right heel with betadine (a topical solution that treats minor cuts, scrapes, burns, and abrasions), cover with a border gauze three times a day as needed. Review of Resident R5's wound care assessment dated [DATE], completed by CRNP, Employee E8 revealed the resident had a right heel unstageable pressure injury. The measurements were 4.7 cm x 3.2 cm. The wound increased in size from 1/26/26. Small amount of sero-sanguineous drainage (a type of wound exudate that is a mixture of serous (a type of fluid that comes out of a wound with tissue damage) fluid and small amounts of blood was noted. Treatment recommendations included to cleanse right heel with normal saline (a sterile solution used primarily for wound irrigation and cleansing), apply xeroform (a sterile, non-adherent petrolatum gauze dressing containing microbial agents, used to protect wounds and promote moist healing while reducing infection risk) cover with dry clean dressing daily, and change as needed. Plan of care and education discussed with facility (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident R13's clinical record revealed a wound care assessment dated [DATE], that indicated that a Deep Tissue Pressure Injury (DTI) was acquired on 12/31/26, on the left lateral ankle (the outside of the ankle). Recommendations included: apply skin prep to the area every other day; continue skin prep to both heels, and apply pillow under left knee to alleviate pressure to calf. Review of Resident R13's clinical record revealed a wound care assessment dated [DATE], indicated that resident still presented with the DTI on the left lateral ankle; continue skin prep to both heels, and apply pillow under left knee to alleviate pressure to calf. Review of Resident R13's clinical record revealed a wound care assessment dated [DATE], indicated that resident still presented with the DTI on the left lateral ankle, and that this wound is deteriorating. Recommendations included: utilize soft heel boots to be on at all times aside from ambulation (walking) for pressure ulcer prevention; continue skin prep to both heels, and apply pillow under left knee to alleviate pressure to calf. Review of Resident R13's medical record revealed that a physician's order dated 1/14/26, to have Medi helix boots (a soft boot designed to prevent pressure ulcers) on at all times. Review of Resident R13's clinical record revealed a wound care assessment dated [DATE], indicated that resident still presented with the DTI on the left lateral ankle, and that resident has BLE contractures and tends to pull left leg up underneath herself putting pressure on lateral left ankle. Recommendations included: utilize soft heel boots to be on at all times aside from ambulation for pressure ulcer prevention; continue skin prep to both heels, and apply pillow under left knee to alleviate pressure. Review of Resident R13's clinical record revealed weekly wound care assessments dated 1/28/26, 2/4/26, 2/11/26, and 2/18/26, that included, but not limited to, all of the above information from previous note dated 1/21/26. Review of Resident R13's clinical record revealed a wound care assessment dated [DATE], that stated left lateral ankle wound is now a Stage Three Pressure Ulcer (pressure injury that have burrowed past the second layer of the skin and reached fat layers beneath). New treatment orders included but not limited to apply Medihoney (a medical grade honey product used to treat wounds), cover with foam dressing change every Monday, Wednesday, and Friday. Previous notes that resident has BLE contractures and tends to pull left leg up underneath herself putting pressure on lateral left ankle; utilize soft heel boots to be on at all times aside from ambulation for pressure ulcer prevention; continue skin prep to both heels, and also to apply pillow under left knee to alleviate pressure, remain in this note. Review of Resident R13's clinical record revealed wound care assessments dated 3/4/26, 3/11/26, 3/18/26, and 3/25/26, included previous data that resident has BLE contractures and tends to pull left leg up underneath herself putting pressure on lateral left ankle. Recommendations included; utilize soft heel boots to be on at all times aside from ambulation for pressure ulcer prevention; continue skin prep to both heels, and apply pillow under left knee to alleviate pressure. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	intervention is required, it needs to be entered as an order so that it will show in the computer system and that staff can be reminded to complete the task and document that it was completed. This would include turning and positioning, pillow placement, and applying boots. During an interview on 7/16/26, at 9:13 a.m. Rehabilitation Director Employee E17 stated that Resident R13 does have contractures, and that sometimes using a brace on a contracture may worsen the skin conditions, and that a Pillow is probably the most effective, to utilize for wound prevention, and healing. Review of Resident R13's clinical record conducted on 7/16/26, failed to reveal the following: no documentation that turning and repositioning resident had occurred until 1/14/26. Review of physician's orders and care plan failed to include evidence that a pillow was ordered, or had been placed under her left knee; and also failed to include evidence that skin prep was ordered to be applied to both heels. During an interview on 7/16/26, at 3:14 p.m. the DON confirmed that the facility failed to implement pressure injury prevention strategies for Resident R13 that were repeatedly recommended by Wound Care CRNP Employee E8, such as placing the pillow under the left knee, and applying skin prep to the heels, as these strategies were not entered into the computer system as an order. Failure to enter these interventions as an order prevented staff from knowing that these strategies should be implemented. The DON confirmed that there was no evidence that pillow placement, and application of skin prep had been completed since December of 2025, and that turning and positioning of Resident R13 was completed prior to 1/14/26. During an interview on 7/16/26, at 3:15 p.m. Wound Care CRNP Employee E8 confirmed that a pillow under Resident R13's left knee Definitely would have helped prevent the pressure ulcer on her left lateral ankle. During an interview on 7/16/26, at 9:32 a.m. Nurse Aide, Employee E9 stated for pressure ulcer prevention, pressure relieving boots, pillows are used for offloading. Residents should also be turned and repositioned every two hours. During an attempted phone interview on 7/16/26, at 12:11 p.m. Wound CRNP, Employee E8 was unavailable for an interview. During an interview on 7/16/26, at 2:05 p.m. Chief Clinical Official Wound Care Consultant, Employee E13 stated resident care and treatment recommendations are transcribed into an order. The wound care consultants notes are entered into the electronic record under progress notes. The facility nurse coordinates to ensure orders are entered into the clinical record. The nurse practitioners are not responsible for entering their own orders. Clinical Official Wound Care Consultant, Employee E13 confirmed Wound CRNP, Employee E8 is the provider that rounds at the facility and is not responsible for entering orders into the resident's clinical record. Facility staff are to enter the physician orders and Wound CRNP, Employee E8 signs the orders off. During a phone interview on 7/16/26, at 2:10 p.m. Wound Care Nurse, Employee E7 stated she (continued on next page)		

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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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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	conducts weekly rounds with the wound care nurse practitioner every Wednesday at the facility. It was indicated Wound Care Nurse, Employee E7 provides Wound CRNP, Employee E8 a list of residents each week for needs to be evaluated. During wound rounds, Wound Care Nurse, Employee E7 keeps track of orders for treatments and inputs orders and care plans. The recommendations for treatment are transcribed into an order. Wound Care Nurse, Employee E7 stated skin prep does require an order and it must be signed off in the electronic record. For interventions such as offloading boots, and turning and repositioning, it is entered so that it populates under nurse aide tasks to sign off as completed, that way I am ensuring nurse aides are documenting as well as nurses to ultimately ensure it is getting done. Wound Care Nurse stated interventions for contractures include utilizing devices such as wedges, braces, or a pillow for different repositioning, which should be entered as an order. During a phone interview on 7/16/26, at 3:14 p.m. Wound CRNP, Employee E8 stated the facility is provided with preventative and treatment orders such as offloading measures and wound treatments. Wound CRNP, Employee E8 confirmed the facility is responsible for entering the orders. Wound CRNP, Employee E8 confirmed Resident R13 skin is prone to breakdown and should have had a pillow in between lower leg and ankle. The Nursing Home Administrator (NHA) and DON were notified of the Immediate Jeopardy (IJ) situation on 7/16/26, at 4:26 p.m. An Immediate Action Plan was requested and the IJ template was provided to the NHA. The Immediate Action Plan was accepted on 7/16/26, at 7:36 p.m. The plan included: Whole house audit will be conducted on all residents by the Director or Nursing/designee to ensure Care plans match the current resident condition by July 17, 2026. All residents will have a Braden completed by the primary nurse assigned by July 17, 2026. The DON or designee will audit the pressure injury orders from last wound report dated July 15, 2026 to ensure reconciliation with resident orders completed by July 17, 2026. All residents will be provided with a head-to-toe skin assessment to ensure that there are no new pressure injuries, This will be done by the primary assigned nurses on the units. This will be completed on July 17, 2026. Education to the designated wound nurse will be provided by the Staff Development Coordinator/designee on the expectations of her coordination and implementation with the Wound and Vascular teams recommendations and orders by July 17, 2026. Education will be provided to CNA, LPN, Therapy, RN, Dietary staff on pressure injuries using the directed in-service power point from CHR Consulting Services by the Staff Development Educator or designee which includes preventative measures, interventions, and care planning and what to do (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	when they identify missing preventative measure, interventions, and care plans . This power point reference F 686, Pressure Ulcer Prevention and Treatment. This will be completed by July 17, 2026 or prior to next shift. Our Wound Care: Treatment (Policy N-W-60) and Wound Care &ndash; Pressure Ulcer/Injury Prevention (Policy N-W-45) will be reviewed by [NAME] Executive Director and Chief Nursing Officer by July 17, 2026 and revised as needed. Weekly audits will be conducted by the DON or designee to ensure that pressure injuries are not worsening. If they are worsening, new interventions will be implemented by nursing to decrease the risk of worsening. Audits will be conducted weekly by the DON or designee on 5 random residents with pres		

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of resident fund reports, and staff and resident interviews, it was determined that the facility failed to provide quarterly resident trust fund (resident funds account with current accounts open and holding resident monies) statements for three of three residents (Residents R12, R23, and R48), and failed to accurately account for resident personal funds for one of three residents (Resident R48). Findings include: Review of the facility trust fund account dated 7/16/26, indicated the following residents had active resident fund accounts: Residents R12, R23, and R48. Further review of facility business records and resident records did not include evidence that the residents were provided with quarterly statements. During a phone interview on 7/16/26, at 11:30 a.m. Revenue Accounting Manager Employee E10 stated that quarter one statements were not sent out to residents or resident representatives and confirmed that the facility failed to have documented evidence for the previous quarters as well. During an interview on 7/16/26, at 11:41 a.m. Assistant Business Office Manager (ABOM) Employee E2 confirmed that the facility could not provide evidence of sending quarterly statements to residents or resident representatives, and the facility failed to provide quarterly resident fund statements for Residents R12, R23, and R48, as required. Review of the clinical record indicated Resident R48 was admitted to the facility on [DATE]. During a review of Resident R48's resident fund statement on 7/15/26, indicated the facility received one payment on 4/17/26. On 5/13/26, Resident R48's resident fund only had one month's worth of allotted amount of money in the resident fund account. During an interview on 7/16/26, at 11:50 a.m. the ABOM Employee E2 stated It appears that the facility only got one lump payment that included the residents stay from September 2025, through April 2026. When the facility got that payment, the computer recognized it as one month payment and only took out one month resident fund allowance and placed it in Resident R48's account. The facility should have transferred eight months of monthly allowance into the account. We moved the correct amount to the account today. During an interview on 7/16/26, at 12:01 a.m. the ABOM Employee E2 confirmed that the facility failed to have an accurate resident personal fund statement for Resident R48. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a) Resident rights.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, and staff interviews, it was determined that the facility failed to develop and implement care plans that included instructions to provide person centered care for four of eight residents (Resident R1, R59, R61, and R123).Based on a review of facility policy, clinical records, and staff and resident interviews, it was determined that the facility failed to develop and implement care plans that included instructions to provide person centered care for four of eight residents (Resident R1, R59, R61, and R123). Findings include: Review of facility's policy Assessment-Comprehensive Person-Centered Care Planning dated 5/28/26, indicated the facility will document, develop, and implement a comprehensive person-centered care plan for all residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Practitioner orders, Medication and Treatment Administration records, progress notes which include treatment plans are part of the whole resident comprehensive person-centered care plan. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses of high blood pressure, anemia (a condition in which the body does not have enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), and adult failure to thrive. Review of Resident R1's hospital Discharge summary dated [DATE], revealed the resident the resident had bladder mass and the plan included to monitor for hematuria (blood in urine), consider urology appointment, in case of worsening hematuria, surgical pathology from 5/15/26 pending, continue 0.4 mg Flomax (medication primarily used to treat benign prostatic hyperplasia (BPH), a condition in which the prostate gland enlarges and obstructs urine flow) daily. The resident had an acute pulmonary embolism (a blockage in one of the pulmonary arteries in the lungs, usually caused by blood clots that travel to the lungs from the legs or other parts of the body (deep vein thrombosis) and the plan included to continue Eliquis (blood thinning medication to reduce the risk of clot formation) twice a day, administer 20 mg Lasix (a loop diuretic (water pill) that helps the body eliminate excess water and salt by increasing urine output) for five days and to continue if resident remains hypervolemic (a condition where there is too much fluid in the body), monitor input and outputs, and to continue dysphagia diet. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/31/26, failed to include above diagnoses. Section I: Active Diagnoses failed to include diagnoses of pulmonary embolism, and bladder mass. Review of Resident R1's care plan on 7/15/26, failed to include a care plan with goals and interventions for the resident's pulmonary embolism and bladder mass. Interview on 7/15/26, at 12:19 p.m. Registered Assessment Coordinator (RNAC), Employee E7 stated I didn't know he had a pulmonary embolism. RNAC, Employee E7 confirmed the resident's care plan failed to include interventions related to the resident's pulmonary embolism and bladder mass. Review of the clinical record indicated Resident R59 was admitted to the facility on [DATE], with diagnoses of lymphedema (condition characterized by swelling caused by an accumulation of protein-rich fluid in the body's tissues), morbid obesity, and muscle wasting and atrophy. Review of Resident R59's MDS dated [DATE], indicated the diagnoses were current. Review of Resident R59's care plan dated 3/24/20, indicated to apply lymphedema pumps to both legs for edema, no more than 60 minutes per leg. The care plan was updated 12/22/25, with interventions to apply lymphedema wraps to right leg as ordered and as tolerated. Review of Resident R59's physician order dated 6/22/26, indicated to apply lymphedema pump to left leg as tolerated, no more than 60 minutes at a time at bedtime. Nursing to call resident's brother if resident refuses. Review of Resident R59's June Treatment Administration (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record revealed the following: -6/25/26, 8:47 p.m. the lymphedema pump was not applied to left leg as tolerate, no more than 60 minutes at a time because the resident stated it doesn't work. -6/26/26, 9:36 p.m. the lymphedema pump was not applied to left leg as tolerate, no more than 60 minutes at a time because the Resident states that pumps not working again and has an error msg to call 1-800 number. -6/27/26, at 7:27 p.m. the resident refused -6/28/26, at 7:31 p.m. the resident refused Review of Resident R59's care plan revised 7/7/26, indicated the resident has the right to refuse care and services, interventions included to educate the resident on the importance of use of lymphedema pumps. Review of Resident R59's July Treatment Administration Record revealed the following: -7/10/26, at 9:41 p.m. the resident refused. States that it is broken and keeps having an error message to call 1-800 number. -7/11/26, at 8:59 p.m. the resident refused. States she wanted a number to call to get them serviced and waiting for someone to sit with her for call. -7/12/26, at 8:22 p.m. the resident refused. -7/13/26, at 7:32 p.m. the resident states pump not working properly. -7/14/26, at 8:54 p.m. the resident refused. Resident refused, stated she has to call the 1-800 number tomorrow because they aren't inflating properly. During an interview and observation on 7/13/26, at 11:28 a.m. Resident R59 stated they haven't been able to use their lymphedema pumps for a while. It was indicated they both initially inflate, but they don't stay filled and inflated. It was indicated they have been dealing with this issue for over a year and believes staff do not believe her. Resident R59's lymphedema pumps were observed sitting in a box next to their nightstand in the corner. Review of Resident R59's clinical record failed to include evidence the resident was educated on the importance of use of lymphedema pumps when refused or that nursing called the resident's brother if resident refuses. The facility failed to implement the care plan interventions related to the resident's lymphedema pumps. During an interview on 7/15/26, at 9:59 a.m. the DON confirmed the facility was made aware of the allegation of the broken pumps and on 6/22/26, they lymphedema pumps were in working order. During an interview on 7/15/26, at 9:02 a.m. Registered Nurse (RN), Employee E9, stated she put the lymphedema pumps on Resident R59 a few weeks ago, and the machine came on, and once she left the room and returned there was an error message. It was indicated the resident was not nappy, and it's been an ongoing issue. During an interview and observation on 7/15/26, at 9:04 a.m. Resident R59's lymphedema pumps were observed sitting in a box next to their nightstand in the corner. Resident R59 stated they were not used last evening. Review of the clinical record failed to include evidence the resident's brother was notified if the resident refuses and failed to provide evidence the resident was educated on importance of lymphedema pumps when refused. During an interview on 7/15/26, at 10:26 a.m. the Director of Nursing confirmed the facility failed to implement the resident's care plan and apply lymphedema pumps as ordered. Review of the clinical record indicated Resident R61 was admitted to the facility on [DATE], with diagnoses of lymphedema, morbid obesity, and muscle wasting and atrophy. Review of Resident R61's care plan dated 6/28/26, revealed a care plan with a category of behavioral symptoms. It was indicated the resident had high blood pressure and heart failure and uses oxygen continuously. Interventions included to monitor for tolerance to activities/self-care (fatigue, shortness of breath, pallor (unusually pale skin) or cyanosis (a bluish discoloration of the skin due to poor circulation or inadequate oxygenation of the blood), vertigo (feeling of spinning), weakness, etc.). Ensure oxygen is placed, check oxygen saturation (measures the fraction of hemoglobin molecules in the blood that are carrying oxygen at a given time) as needed for shortness of breath. Review of Resident R61's MDS dated [DATE], indicated the diagnoses were current. During an observation on 7/13/26, Resident R61 was observed utilizing oxygen with humidification. Review of Resident R61's physician order dated 6/26/26, indicated to administer 2 Liters (L) of oxygen at all times. Review of Resident R61's care plan on 7/15/26, failed (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to include interventions related to the resident's humidification and oxygen tubing. Review of the clinical record indicated Resident R123 was admitted to the facility on [DATE], with diagnoses of chronic respiratory failure with hypoxia, lymphedema, and anxiety. Review of Resident R123's MDS dated [DATE], indicated the diagnoses were current. Review of Resident R123's care plan dated 7/20/22, indicated the resident has the potential for respiratory distress due to requiring oxygen, sleep apnea. Review of Resident R123's physician order dated 7/28/24, indicated to administer 3 (L) of oxygen from 8:00 a.m. to 8:00 p.m. titrate to keep blood oxygen saturation above 92%. Review of Resident R123's physician order dated 2/4/26, indicated to ensure oxygen humidifier bottle is filled appropriately. During an observation on 7/13/26, at 9:36 a.m. Resident R123 was observed receiving oxygen via nasal cannula with humidification. Review of Resident R123's care plan on 7/14/26, failed to include interventions related to the resident's humidification and oxygen tubing. During an interview on 7/15/26, at 9:14 a.m. the Director of Nursing stated if a resident uses oxygen, it is expected they are care planned for oxygen. During an interview on 7/15/26, at 9:15 a.m. Registered Assessment Coordinator (RNAC), Employee E7 confirmed Resident R61's and Resident R123's care plan failed to include care interventions related to Resident R123's humidification and how often to change the oxygen tubing. 28 Pa. Code 211.12(d)(5) Nursing Services.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review, resident and staff interview, it was determined that the facility failed to procure complete physician's orders for residents with an ostomy (an opening into the abdomen that removes waste) for one of three residents (Resident R7), and residents utilizing a bedside commode for two of two residents (Residents R7 and R126). Findings include: Review of the facility policy Transcription-Reconciliation of Practitioner Orders last reviewed 5/28/26, indicated to ensure that all new, changed, and discontinued orders are entered into facility approved forms. Review of Resident R7's clinical record indicated an admission date of 11/9/19. Review of Resident R7's Minimum Data Set Assessment (MDS-A periodic assessment of resident care needs) dated 4/21/26, indicated the diagnosis of hypertension (high blood pressure), depression and right hip fracture. Review of Resident R7's physician orders dated 5/1/26, indicated provide colostomy care every shift. Ensure site is clean, dry, and intact. The orders failed to include specific information that included product type, size of product or frequency in which to change the products. During an observation completed on 7/13/26, at 12:12 p.m. resident was sitting on the edge of her bed getting ready to eat her lunch. A bedside commode was viewed at the foot of her bed. During an observation completed on 7/14/26, at 2:18 p.m. Nurse Aid Employee E5 was observed emptying the bedside commode. Review of Resident R7's current physician orders failed to reveal Resident R7 was to utilize a bedside commode. During an interview completed on 7/14/26, at 2:28 p.m. the Assistant Director of Nursing Employee E1 confirmed that Resident R7 did not have specific orders for a colostomy that included product type, size of product or frequency in which to change the products and that Resident R7 failed to have physician orders for a bedside commode. Review of Resident R126's clinical record indicated an admission date of 11/30/22. Review of Resident R126's MDS dated [DATE], indicated the diagnosis of heart failure (the heart doesn't pump the way it should), diabetes (high sugar in the blood) and hyperlipidemia (high fat in the blood). During an observation completed on 7/13/26 at 9:52 a.m. Resident R126 was in her bed. A bedside commode was noted to the left side of the bed. During an observation completed on 7/15/26, at 9:11 a.m. the bedside commode was noted to the left side of Resident R126's bed. Review of Resident R126's current physician orders failed to reveal Resident R126 was to utilize a bedside commode. During an interview completed on 7/15/26, at 9:16 a.m. Registered Nurse Employee E6 confirmed that Resident R126 did not have physician orders for the bedside commode and that the facility failed to procure complete physician's orders for Resident R126's bedside commode. 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(5) Nursing services.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observations, and resident and staff interviews, it was determined that the facility failed to have sufficient nursing staff to provide nursing, and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of one of three nursing units (Three East), and two of five residents (Group Resident (GR)1, and GR2)Findings include: During an observation of the lunch meal on 7/13/26, at 12:07 p.m. no residents were eating in the Third-Floor East Dining Room. During an interview on 7/13/26, at 12:07 p.m. Nurse Aide (NA) Employee E20 confirmed that no resident would be dining in the Dining Room on this day, and stated: When we have six aides, we use the Dining Room, today we only have five, and stated that they need extra aides to get the residents up, and ready to transport them down to the Dining Room. During an observation, and interview on 7/14/26, at 12:15 p.m. no residents were observed eating in the Third Floor East Dining Room, and NA Employee E20 confirmed the above observation, and stated that they only had five aides again today. During a group interview on 7/15/26, at 10:24 a.m. two of five residents (GR1, and GR2) stated that they could not eat in the Dining Room when there wasn't enough staff. During an interview on 7/18/26, at 1:44 p.m. the Nursing Home Administrator confirmed that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of three nursing units. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(e)(6) Management.28 Pa. Code: 211.12(d)(1)(4) Nursing services.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of personnel records and staff interview, it was determined that the facility failed to complete annual performance evaluation at least once every 12 months for three of five nurse aide (NA) personnel records (NA Employee E23, E25, and E26). Findings include: Review of NA Employee E23's personnel record indicated a hire date of 6/7/21. Review of NA Employee E23's personnel records revealed a performance evaluation was conducted on 5/29/25, and no other performance evaluation has been completed since 5/29/25. Review of NA Employee E25's personnel record indicated a hire date of 6/27/16. Review of NA Employee E25's personnel records revealed a performance evaluation was conducted on 6/6/25, and no other performance evaluation has been completed since 6/6/25. Review of NA Employee E26's personnel record indicated a hire date of 1/16/24. Review of NA Employee E26's personnel records revealed a performance evaluation was conducted on 2/6/25, and no other performance evaluation has been completed since 2/6/25. During an interview on 7/18/26, at 10:11 a.m. the Nursing Home Administrator confirmed that the facility failed to complete annual performance evaluation at least every 12 months for NA Employee E23, E25 and E26. 28 Pa Code: 201.14 (b) Responsibility of licensee 28 Pa Code: 201.18 (b)(1)(3) Management		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to prevent cross contamination during a medication pass, failed to follow Enhanced Barrier Precautions (EBP- infection control measures recommended by the Center for Disease Control (CDC) to reduce the transmission of multidrug-resistant organisms (MDROs) for one of three residents (Resident R7), failed to prevent cross contamination during a dressing change (Resident R13), and failed to conduct an assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread for twelve of twelve months (April 2025 to April 2026). Findings include: Review of Center for Disease Control (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers dated 2/27/24, stated washing your hands with soap and water include the following: -Wet hands with water. -Apply the manufacturer recommended amount of product to your hands. -Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. -Rinse hands with water and use disposable towels to dry. Use a towel to turn off the faucet. -Avoid using hot water to prevent drying of the skin Review of the facility policy Infection Prevention and Control Program and Plan last reviewed 5/28/26, indicated it is the policy of the facility to establish and maintain an infection prevention and control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. Staff utilize Enhanced Barrier Precautions as indicated, staff perform hand hygiene as indicated and use personal protective equipment (PPE). Review of the facility policy Medication Administration General Guidelines last reviewed 5/28/26, indicated to provide direction in the safe and effective administration of medications, including preparation and technique to store and handle medications in accordance with manufacture recommendations and/or stated and federal requirements. Review of the facility's water management plan last reviewed 5/28/26, revealed it is the facility's policy to reduce Legionella Growth and Spread indicated it is recommended that a facility-wide chlorination procedure be completed at least twice a year, but no less than annually. The Environmental Service Department will ensure that all water sources that are not used on a regular basis be placed on a weekly flushing system. Those flushes will be conducted to help reduce the build-up of dirt, debris, and/or bacteria. Any taps found to show blackish debri or general dirt will be (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	flushed until they run clear. All resident shower rooms will be placed on a weekly flush to ensure the constant flow of water and prevent legionella growth. During a medication pass observation completed on 7/14/26, at 9:15 a.m. Registered Nurse (RN) Employee E11 was preparing the medications for Resident R37. RN Employee E11 applied gloves to both hands. RN employee E11 then punched out the medication from the dispensing pack directly into her right hand and used her left hand to pluck the medication out of her right hand and place the medication into the medication cup. This process continued with all the medications scheduled for Resident R37's morning medications. RN Employee E11 confirmed touching the medications prior to placing into the medication cup and stated, but I was wearing gloves and confirmed that the facility failed to prevent cross contamination during a medication pass. Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE]. Review of Resident R7s Minimum Data Set (MDS - a period assessment of care needs) dated 5/21/26, indicated diagnoses of anemia (low iron in the blood), urinary tract infection, and right hip fracture. Review of Resident R7's physician orders dated 6/3/26, indicated multi drug resistant organism (MDRO) related to Extended-Spectrum Beta-Lactamase (ESBL) Escherichia coli (E-coli- bacteria normally found in the gut that enters the urinary tract). Special instruction MDRO is colored purple. Confirm isolation bin is on resident's door, confirm bin is stocked with PPE, if not notify housekeeping. During an observation and interview completed on 7/14/26, at 2:18 p.m. Nurse Aid (NA) Employee E5, was emptying Resident R7's bedside commode. NA employee E7 was not utilizing the required PPE. Upon asking NA Employee E7 concerning the purple sticker on the door replied, I don't know why they have the purple sticker, the pink one is for her ostomy bag. Upon asking concerning utilizing the appropriate PPE replied, I would wear a gown if doing her ostomy care and pointed to the pink dot on the door. I don't know of anything in her urine and confirmed the facility failed to follow EBP to reduce the transmission MDROs for one of three residents (Resident R7). Review of Resident R13's clinical record indicated that she was admitted to the facility on [DATE], and readmitted [DATE]. Review of Resident R13's MDS dated [DATE], indicated diagnoses of high blood pressure, difficulty swallowing, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Resident R13's physician order dated 5/29/26, revealed an order for enhanced barrier precautions (infection control measures designed to reduce the transmission of multidrug-resistant organisms (MDROs) in healthcare settings, that involve the use of gown and gloves during high-contact resident care activities for residents known to be colonized or infected with MDROs, as well as those at increased risk of MDRO acquisition, such as residents with wounds or indwelling medical devices.) due to wound. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R13's physician order dated 6/24/26, revealed an order to cleanse left lateral ankle pressure injury with Dankins (antiseptic used to cleanse wounds and prevent infection) solution 0.125%, apply small amount of mupirocin (an antibacterial drug) ointment and santyl (a prescription collagenase ointment used to remove dead tissue from chronic skin ulcers and severe burns, promoting wound healing) to wound bed, cover with foam dressing daily. During an observation of Resident R13's wound dressing change on 7/16/26, at 11:13 a.m. completed by Licensed Practical Nurse (LPN), Employee E4 the following was observed: -LPN, Employee E4 failed to wash hands prior to donning gown and gloves -LPN, Employee E4 entered the hallway with doffed gown and gloves -LPN, Employee E4 failed to wash hands prior to opening supplies -LPN, Employee E4 placed wound dressing supplies on unclean surface while preparing wound care supplies -LPN, Employee E4 placed contaminated wound care supplies on clean surface and failed to prevent cross-contamination -LPN, Employee E4 failed to wash hands for a total of 15 seconds -LPN, Employee E4 failed to turned off the faucet with hand creating the potential for cross contamination -LPN, Employee E4 entered into hallway prior to doffing gown -LPN, Employee E4 failed to clean bed side table that was utilized after dressing change was complete During an interview on 7/16/26, at 11:54 p.m. LPN, Employee E4 confirmed the above observations and that the facility failed to perform appropriate hand hygiene, discard personal protective equipment, and prevent the potential for cross contamination. During an interview on 7/16/26, at 12:00 p.m. the Director of Nursing confirmed the facility failed to prevent the potential for cross contamination and perform hand hygiene during a wound dressing change for Resident R13. During an interview on 7/17/26, at 12:12 p.m. Plumber, Employee E31 stated the fixtures on the 2nd floor on the closed units must be flushed weekly at minimum. Review of facility provided documents failed to include evidence the closed unit located on the 2nd floor had weekly flushing completed from 4/1/25, to 4/31/26. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/17/26, at 2:42 p.m. Epidemiologist, Employee E30 confirmed the facility failed to implement their water management plan to prevent the growth of legionella by failing to conduct weekly flushes for the closed unit located on 2 [NAME] from April 2025, to April 2026. 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10 (d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing services.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interview, it was determined that the facility failed to inform a resident or resident's representative in advance of the proposed care, including the risk and benefits of the prescribed medication for one of five residents (Resident R103). Findings include: Review of the clinical record indicated Resident R103 was admitted to the facility on [DATE]. Review of Resident R103's Minimum Data Set (MDS - a period assessment of care needs) dated 6/22/26, indicated diagnoses of anxiety, depression and Amyotrophic lateral sclerosis (ALS-progressive disease that affects nerve cells controlling voluntary muscles, leading to muscle weakness, atrophy, and eventually loss of movement, speech, and breathing). Review of Resident R103's physician orders dated 1/1/26, indicated Duloxetine (Celexa) capsule (used to treat depression), delayed release 30 milligrams(mg) 1 capsule by mouth twice a day for major depressive disorder. Review of Resident R103's physician orders dated 6/8/26, indicated Lorazepam (Ativan) 0.5 mg 1 tablet three times a day for anxiety. Review of Resident R103's clinical record failed to include a signed consent form for Duloxetine or Lorazepam that included the risk and benefits of the prescribed medication. During an interview completed on 7/16/26, at 2:00 p.m. the Assistant Director of Nursing Employee E1 did provide a consent for the duloxetine and lorazepam, however, the form failed to contain a signature from the resident or the residents responsible party and confirmed that the that the facility failed to inform a resident's or resident representative in advance of the proposed care, including the risk and benefits of the prescribed medication for one of five residents (Resident R103). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a): Resident rights.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to maintain the confidentiality of residents' medical information for one of three nursing stations (Third floor East) and failed to maintain the confidentiality of residents' medical information for one of five medication carts (Third floor medication cart ten). Findings include: During an observation completed on 7/15/26, at 1:12 p.m. the Third-floor East Nursing Station had therapy schedules and nurse aid worksheets containing resident personal and confidential information sitting on the counter available to anyone passing the area to view. During an interview completed on 7/15/26, at 1:19 p.m. Registered Nurse Employee E6 confirmed that the therapy schedules and nurse aid worksheets containing resident personal and confidential information were sitting on the counter available to anyone passing the area and that the facility failed to maintain the confidentiality of residents' medical information for one of three nursing stations (Third-floor East). During an observation on 7/15/26, at 1:17 p.m. in the Third-Floor East hallway, medication cart number ten was left unattended with the computer screen open, which revealed identifiable, personal, and confidential resident information that any passerby could see. During an interview on 7/15/26, at 1:19 p.m. Registered Nurse Employee E6 confirmed the above observation, and that the facility failed to maintain confidentiality of a resident's medical information as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.29(c.3) Resident Rights. 28 Pa. code: 211.5(b) Medical records. 28 Pa. Code: 211.12(d)(1)(3) Nursing services.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy, and staff interviews, it was determined that the facility failed to ensure that residents' medication regime was free from unnecessary psychotropic (a mind-altering medication) medication for two of three residents (Resident R5 and R103). Findings include: Review of the facility policy Standards of Practice for Rx Partners INC. Consultant Pharmacists last reviewed 5/28/26, indicated that the consultant pharmacist reviews the drug regimen of each resident and medical chart at least monthly, reports and documents any irregularities to the residents nursing staff and/or attending physician. Review of the facility policy Unnecessary Medication Monitoring last reviewed 5/28/26, indicated unnecessary medications are defined as any medication when used in excessive dose, or for excessive duration or without adequate monitoring, or without adequate indications for use. Psychotropic Dugs are any drug that affects brain activities associated with mental process and behavior. Theses drugs include but not limited to: Antipsychotics, Antidepressant, Antianxiety and Hypnotics. Review of the clinical record revealed that Resident R5 was admitted to the facility on [DATE], with diagnoses of muscle weakness, anxiety, and depression. Review of Resident R5's care plan dated 1/28/25, revealed the resident was on antidepressant/antianxiety medication. Interventions included to observe for side effects of antidepressant/antianxiety such as headaches, drowsiness, insomnia, nervousness, constipation, dry mouth, or complaints of ringing in ears, lethargy. Review of Resident R5's physician order dated 7/10/25, indicated to administer half a tablet of 0.5 mg lorazepam, once a day as needed for anxiety. There was no stop date. The order was discontinued on 7/28/25, at total of 18 days later. The facility failed to limit as need psychotropic drugs to 14 days. Review of Resident R5's Minimum Data Set (MDS, periodic assessment of resident care needs) dated 7/25/25, indicated the diagnoses were current. Section N0145. High-Risk Drug Classes: Use and Indication revealed the resident was taking an antianxiety medication. Review of Resident R5's physician order dated 7/28/25, indicated to administer half a tablet of 0.5 mg lorazepam, once a day as needed for 180 days for ongoing/chronic anxiety. The order was discontinued on 12/6/25. Review of Resident R5's psychiatric note dated 8/12/25, revealed the resident was on as needed lorazepam that was added by the medical doctor since 7/28/25. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R5's psychiatric note dated 10/21/25, revealed the resident was on as needed lorazepam that was added by the medical doctor since 7/28/25. Review of the clinical record from 7/10/25, to 12/6/25, failed to include the attending physician's or prescribing practitioner's rationale for the as needed lorazepam order to be extended beyond 14 days. During an interview on 6/4/26, at 11:29 a.m. the Assistant Director of Nursing, Employee E1 confirmed Resident R5 was ordered as needed lorazepam from 7/10/25, to 7/28/25, and 7/28/25, to 12/6/25, and the clinical record failed to provide a rationale as to why the medication was ordered past 14 days and confirmed that the facility failed to ensure that residents medication regimen was free from unnecessary psychotropic medications for Resident R5. Review of the clinical record indicated Resident R103 was admitted to the facility on [DATE]. Review of Resident R103's MDS dated [DATE], indicated diagnoses of anxiety, depression and Amyotrophic lateral sclerosis (ALS-progressive disease that affects nerve cells controlling voluntary muscles, leading to muscle weakness, atrophy, and eventually loss of movement, speech, and breathing). Review of Resident R103's physician orders dated 1/1/26, indicated Wellbutrin XL extended release 150 milligram tablet by mouth daily for major depressive disorder. Review of Resident R103's physician orders dated 1/1/26, indicated duloxetine (also known as Celexa) capsule delayed release 30 milligrams (mg) 1 capsule by mouth twice a day for major depressive disorder. Review of Resident R103's physician orders dated 6/8/26, indicated lorazepam (also known as Ativan) 0.5 mg 1 tablet three times a day for anxiety. Review of Resident R103's clinical record failed to indicate any documented non-pharmacological interventions or effectiveness of pharmacological interventions; the clinical record also failed to indicate evidence that the facility had implemented side effect or behavior monitoring for psychotropic medication use. During an interview completed on 7/16/26, at 2:00 p.m. the Assistant Director of Nursing Employee E1 confirmed that Resident R103's clinical record failed to indicate any documented non-pharmacological interventions or effectiveness of pharmacological interventions; the clinical record also failed to indicate evidence that the facility had implement side effect or behavior monitoring for psychotropic medication use. 28 Pa. Code 211.2(d)(3) Medical director 28 Pa. Code 211.10(a) Resident care policies		

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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. Based on reviews of facility policy, facility documents, clinical records and staff interviews it was determined that the facility failed to implement written policies and procedures to ensure a complete, thorough and timely investigation was completed for one of two residents (Resident R72). Findings include: Review of the facility policy Abuse-Resident and Reasonable Suspicion of a crime dated 5/28/26, indicated it is the policy of this facility to treat every resident with consideration, respect and full recognition of his/her dignity and individuality. This policy is part of the center's overall prevention of abuse, neglect, exploitation and misappropriation of resident property. 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. Every complaint or allegation of resident abuse shall be promptly reported to the Administer and an investigation initiated. The house Registered Nurse Supervisor/Designee initiates investigation promptly. Assures that the Nursing Home Administrator (NHA) and Director of Nursing (DON) are notified promptly. Interviews and obtain written statements from complaining party and witnesses. Completes Incident Report and notifies practitioner. Updates resident's person-centered care plan promptly. Consults with the interdisciplinary team (IDT) for person centered care plan updates to address the residents medical, nursing, physical, or psychosocial needs or preferences. Review of Resident R72's clinical record indicated an admission date of 9/23/25. Review of Resident R72's Minimum Data Set (MDS-a period assessment of care needs) dated 6/3/26, indicated the diagnosis of hypertension (high blood pressure), diabetes (high sugar in the blood) and anxiety. Review of physician orders dated 11/25/25, revealed Resident R72 transfers with assistance of two. Review of nursing progress notes dated 1/5/26, revealed Nurse Aid (NA) notified nurse and supervisor that resident had been lowered to the floor by herself. There were no injuries from this event. All vital signs are within normal limit per baseline. Safety maintained, will monitor. Call light, fluids, and personals are all within reach. Review of nursing progress note dated 1/7/26, revealed Resident R72 status post fall vital signs stable. No complaints of pain or distress noted at this time. Resting in chair. Assisted with all needs by nursing staff. Call bell within reach. Plan of care continues. Review of facility progress notes revealed during a care conference held 1/13/26, Resident R72's representative was given a grievance form based on a care concern. Representative stated he would fill it out and bring it back to the facility during his next visit. Review of physician progress note dated 1/14/26, physician monthly note revealed seeing the patient today for routine assessment. She states she is feeling well today. Using hearing aids for hearing loss. Good appetite. Sleeping well. She does report a minor fall last week but states she was not injured. She was being assisted to transfer into bed and stated she could not stand any longer and was lowered to the floor, this occurred 1/5/26. Review of nursing progress notes failed to reveal any further documentation concerning Resident R72 being lowered to the floor by NA on 1/5/26. During an interview completed on 7/16/26, at 10:15 a.m. upon asking the Director of Nursing concerning the event that took place on 1/5/26, stated I was not employed here when it happened. From what I reviewed it seemed that Resident R72 was transferred with assist of one, it was from a grievance received later. I'm not really sure. During a telephonic interview completed on 7/16/26, at 10:45 a.m. upon asking Licensed Practical Nurse Employee E14 concerning the event that took place on 1/5/26, stated I notified the supervisor as soon as it happened. She would have been the one to notify. Resident R72 was lowered to the floor by a NA, no injuries as far as I can remember. During an interview completed on 7/17/26, at 11:10 a.m. upon asking Registered Nurse Assessment Coordinator (RNAC) Employee E12 (former Director of (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing) concerning Resident R72's event replied I was not in the facility when it happened, I just know from the grievance I received on 1/23/26, that's when I started the investigation. I don't know if it was reported to other administration staff. I just know what I did from 1/23/26, and reviewed the investigation statements, and confirmed that the facility failed to implement written policies and procedures to ensure a complete and thorough investigation in a timely manner for one of two residents (Resident R72). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **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 ensure the resident's representative was provided with written a notice of transfer for one of four residents (Resident R1), and 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 one of four resident hospital transfers (R103). Findings include: Review of facility policy Bed Holds and Return dated 5/18/26, indicated all residents or representatives are provided with written information regarding the facility bed hold policies upon admission, upon hospital transfer, and upon therapeutic leave of absence. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses of high blood pressure, anemia (a condition in which the body does not have enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), and adult failure to thrive. Review of the clinical record indicated Resident R1 was transferred to the hospital on 5/23/26. Review of Resident R1's clinical record revealed the resident was not responsible for self. Review of Resident R1's clinical record failed to include documented evidence that the resident's representative was provided with written a notice of transfer. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/31/26, indicated diagnoses were current. During an interview on 7/15/26, at 1:46 p.m. the Director of Nursing confirmed that the facility failed to maintain documentation that resident's representative were provided a written notice of transfer for Resident R1. Review of the clinical record indicated Resident R103 was admitted to the facility on [DATE]. Review of Resident R103's MDS dated [DATE], indicated diagnoses of anxiety, depression and Amyotrophic lateral sclerosis (ALS-progressive disease that affects nerve cells controlling voluntary muscles, leading to muscle weakness, atrophy, and eventually loss of movement, speech, and breathing). Review of Resident R103's clinical records revealed that on 12/30/25, resident was transferred to the hospital for a change in condition. Review of Resident R103's clinical record revealed that on 12/28/26, resident was transferred to (continued on next page)		

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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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospital for a change in condition. Review of Resident R103'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 [DATE], or 12/28/26. During an interview completed on 7/15/26, at 1:45 p.m. the Director of Nursing confirmed that the 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 [DATE], or 12/28/26. 28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights.		

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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 the Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interviews, it was determined that the facility failed to ensure Minimum Data Set (MDS - a periodic assessment of care needs) accurately reflected the resident's status for one of six residents (Residents R1). Findings include: Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses of high blood pressure, anemia (a condition in which the body does not have enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), and adult failure to thrive. Review of the clinical record indicated Resident R1 was transferred to the hospital on 5/23/26, and readmitted to the facility 5/27/26. Review of Resident R1's hospital discharge summary revealed the resident the resident had a pulmonary embolism, and bladder mass with a history of prostate cancer. Review of Resident R1's MDS dated [DATE], failed to include above diagnoses. Section I: Active Diagnoses failed to include diagnoses of pulmonary embolism, and bladder mass. Interview on 7/15/26, at 12:19 p.m. Registered Assessment Coordinator (RNAC), Employee E7 stated I didn't know he had a pulmonary embolism. RNAC, Employee E7 confirmed the Residents MDS assessment failed to include diagnoses of pulmonary embolism, bladder mass, and history of prostate cancer. Interview on 7/15/26, at 12:24 p.m. the Director of Nursing (DON) confirmed the facility failed to ensure MDS accurately reflected the resident's status for one of six residents (Residents R1). 28 Pa. Code 211.12(c)(d)(5) Nursing services.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on clinical record review, and staff interview, it was determined that the facility failed to ensure that the resident or resident representative received a copy of the baseline care plan and understood the baseline care plan for two of four residents (Resident R1 and R72). Findings include: The facility Assessment Comprehensive Person-Centered care planning policy last reviewed 5/28/26, indicated to assure documentation, development, and implementation of a comprehensive person-centered care plan for all residents to attain or maintain the highest practicable physical, mental and psychosocial wellbeing. The Interdisciplinary Team (IDT) develops and implements a baseline care plan for each resident, within 48 hours of admission, that includes instructions needed to provide effective and person-centered care. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses of high blood pressure, anemia (a condition in which the body does not have enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), and adult failure to thrive. Review of Resident R1's progress note dated 5/22/26, revealed a care conference was held this date. Resident R1 was invited, but did not attend. The resident's representative participated via phone. Care plan was reviewed. Resident R1's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R1 and/or their representative. During an interview on 7/16/26, at 10:55 a.m. the Case Work Supervisor, Employee E18 confirmed there was no evidence that a written summary of the baseline care plan and order summary were provided to Residents R1 or their representative. Review of Resident R72's clinical record indicated an admission date of 9/23/25. Review of Resident R72's Minimum Data Set Assessment (MDS-A periodic assessment of resident care needs) dated 6/3/26, indicated the diagnosis of hypertension (high blood pressure), diabetes (high sugar in the blood) and anxiety. Review of Residents R72's clinical record failed to reveal evidence that a baseline care plan was received by the resident or resident representative. During an interview completed on 7/17/26, at 8:41 a.m. the Assistant Director of Nursing Employee E1 confirmed that that a baseline care plan was not received by Resident R72 or Resident R72's representative and that the facility failed to ensure that the resident or resident representative received a copy of the baseline care plan and understood the baseline care plan. (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12 (d)(1)(3)(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 policies, clinical records, and staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated and revised to reflect the resident's specific care needs for two of three residents (Residents R7 and R72). Findings include: The facility Assessment Comprehensive Person-Centered care planning last reviewed 5/28/26, indicated to assure documentation, development, and implementation of a comprehensive person-centered care plan for all residents to attain or maintain the highest practicable physical, mental and psychosocial wellbeing. The Interdisciplinary Team (IDT) develops, reviews, revises, and implements a comprehensive person-centered care plan for each resident, consistent with resident rights that include measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs. Review of Resident R7's clinical record indicated an admission date of 11/9/19. Review of Resident R7's Minimum Data Set Assessment (MDS-A periodic assessment of resident care needs) dated 4/21/26, indicated the diagnosis of hypertension (high blood pressure), depression and right hip fracture. During an observation completed on 7/13/26, at 12:12 p.m. Resident was sitting on the edge of her bed getting ready to eat her lunch. A bedside commode was viewed at the foot of her bed. During an observation completed on 7/14/26, at 2:18 p.m. Nurse Aid Employee E5 was observed emptying the bedside commode. Review of Resident R7's current care plan failed to have intervention for the bedside commode. During an interview completed on 7/14/26, at 2:28 p.m. the Assistant Director of Nursing Employee E1 confirmed that Resident R7's current care plan failed to have interventions for a bedside commode and that the facility failed to ensure that a resident's care plan was updated and revised to reflect the resident's specific care needs for Resident R7. Review of Resident R72's clinical record indicated an admission date of 9/23/25. Review of Resident R72's MDS dated [DATE], indicated the diagnosis of hypertension, diabetes, and anxiety. Review of Resident R72's care plan with approach start date 10/24/25, indicated ADL assistance needed. Transfer training sit to stand, supine to sit moderate/maximum (MOD/MAX) assist. The care plan failed to indicate the number of staff required for transfers. Review of Resident R72's physician orders dated 11/25/25, revealed ADL-transfers: assist of 2. During an interview completed on 7/17/26, at 11:10 a.m. Registered Nurse Assessment Coordinator (RNAC) Employee E12 confirmed that Resident R72's transfer status was not updated in the care plan with the order change on 11/25/25, and that facility failed to ensure that a resident's care plan was updated and revised to reflect the resident's specific care needs for Resident R72. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(3)(5) Nursing services.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interview, it was determined that the facility failed to properly monitor weight and nutrition status by failing to obtain weights for one of three residents (Residents R12) reviewed. Findings included: Review of the clinical record indicated Resident R12 was admitted to the facility on [DATE]. Review of Resident R12's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/20/26, indicated diagnoses of high blood pressure, heart failure (a progressive heart disease that affects pumping action of the heart muscles), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Resident R12's clinical record revealed weights to be as follows: 1/14/26: 117.1 pounds 2/1/26: 117.4 pounds 3/1/26: 109.1 pounds 3/4/26: 110.0 pounds (a significant weight loss of 6.3% in one month) April 2026: no weight recorded 5/11/26: 111.8 pounds Review of Resident R12's clinical record revealed a Nutrition progress note dated 3/20/26, that confirms that resident had a significant weight loss in March 2026. During an interview on 7/17/26, at 9:35 a.m. RD Employee E5 confirmed that Resident R12, had significant weight loss in March 2026 and that the facility failed to obtain her weight in April 2026. As a result the facility failed to properly monitor weight and nutrition status by failing to obtain weights for one of three residents (Residents R12) reviewed. 28 Pa Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interviews it was determined that the facility failed to provide appropriate respiratory care for two of four residents (Residents R61 and Resident R123). Findings Include: Review of the Oxygen Guideline policy last reviewed 5/28/26, indicated it is the facility policy to administer oxygen when prescribed to provide comfort and improve quality of life. Sets ups (cannulas, face masks, respiratory delivery, humidification bottles) should be changed at least every seven days and are labeled with date of change initiated by staff. Humidification bottles should be filled with distilled water and should be checked every shift and filled if needed. Review of the clinical record indicated Resident R61 was admitted to the facility on [DATE], with diagnoses of lymphedema, morbid obesity, and muscle wasting and atrophy. Review of Resident R61's physician order dated 6/26/26, indicated to administer 2 Liters (L) of oxygen at all times. Review of Resident R61's care plan dated 6/28/26, revealed a care plan with a category of behavioral symptoms. It was indicated the resident had high blood pressure and heart failure and uses oxygen continuously. Interventions included to monitor for tolerance to activities/self-care (fatigue, shortness of breath, pallor (unusually pale skin) or cyanosis (a bluish discoloration of the skin due to poor circulation or inadequate oxygenation of the blood), vertigo (feeling of spinning), weakness, etc.). Ensure oxygen is placed, check oxygen saturation (measures the fraction of hemoglobin molecules in the blood that are carrying oxygen at a given time) as needed for shortness of breath. Review of Resident R61's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/2/26, indicated the diagnoses were current. During an observation on 7/13/26, Resident R61 was observed utilizing oxygen. The humidification canister was empty and there was no date observed on the resident's nasal cannula tubing. During an interview on 7/13/26, at 10:30 a.m. Licensed Practical Nurse (LPN), Employee E19 confirmed the resident's humidification canister was empty and the nasal cannula tubing was undated. Review of the clinical record indicated Resident R123 was admitted to the facility on [DATE], with diagnoses of chronic respiratory failure with hypoxia, lymphedema, and anxiety. Review of Resident R123's MDS dated [DATE], indicated the diagnoses were current. Review of Resident R123's care plan dated 7/20/22, indicated the resident has the potential for respiratory distress due to requiring oxygen and sleep apnea. Review of Resident R123's physician order dated 7/28/24, indicated to administer 3 Liters (L) of oxygen from 8:00 a.m. to 8:00 p.m. titrate to keep blood oxygen saturation above 92%. Review of Resident R123's physician order dated 2/4/26, indicated to ensure oxygen humidifier bottle is filled appropriately. During an observation on 7/13/26, at 9:36 a.m. Resident R123 was observed receiving oxygen via nasal cannula and the humidification bottle was empty. During an interview on 7/13/26, at 9:44 a.m. Nurse Aide (NA) Employee E9, confirmed Resident R123's humidification was empty. During an interview on 7/15/26, at approximately 3:00 p.m. information was disseminated to the Director of Nursing the facility failed to provide appropriate respiratory care for two of four residents (Residents R61 and Resident R123). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and resident and staff interviews, it was determined that the facility failed to provide pain management consistent with professional standards of practice for one of two residents (Resident R103). Findings include: Review of the facility policy Standards of Practice for Rx Partners INC. Consultant Pharmacists last reviewed 5/28/26, indicated that the consultant pharmacist reviews the drug regimen of each resident and medical chart at least monthly, reports and documents any irregularities to the residents nursing staff and/or attending physician. Review of the clinical record indicated Resident R103 was admitted to the facility on [DATE]. Review of Resident R103's Minimum Data Set (MDS - a period assessment of care needs) dated 6/22/26, indicated diagnoses of anxiety, depression and Amyotrophic lateral sclerosis (ALS-progressive disease that affects nerve cells controlling voluntary muscles, leading to muscle weakness, atrophy, and eventually loss of movement, speech, and breathing). Review of Resident R103's physician orders dated 1/1/26, indicated ibuprofen (Motrin) tablet 800 milligram (mg) tablets one tablet by mouth every 8 hours as needed for left elbow pain. Review of Resident R103's physician orders dated 1/2/26, indicated acetaminophen (Tylenol) tablet 500 mg, 2 tabs by mouth three times a day for pain. Review of Resident R103's physician orders dated 4/17/26, indicated gabapentin (Neurontin) 100 mg capsule 1 capsule by mouth two times a day for nerve pain. Review of Resident R103's physician orders dated 6/13/26, indicated fentanyl (Duragesic) patch 75 micrograms (mcg) /hour (hr) 1 patch every three days for pain left elbow fracture. Review of Resident R103's physician orders failed to indicate any documented non-pharmacological interventions for the use of pain medication. During an interview completed on 7/16/26, at 2:00 p.m. the Assistant Director of Nursing Employee E1 confirmed that Resident R103's clinical record failed to indicate any documented non-pharmacological interventions for the use of pain medication and that the facility failed to provide pain management consistent with professional standards of practice for one of two residents (Resident R103). 28 Pa. Code 211. 10(c) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services		

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure that a physician supervised care in a timely manner for one of 12 sampled residents. (Resident R5) Findings include: Review of the clinical record revealed that Resident R5 was admitted to the facility on [DATE], and readmitted [DATE], with diagnoses of muscle weakness, muscle wasting and atrophy, and Parkinson's Disease (a disorder of the nervous system that affects movement and gets worse over time). Review of Resident R5's care plan initiated 8/18/25, indicated the resident remained a high risk for pressure injuries due to decreased mobility, incontinence, decrease in nutrition, and decline in overall medical condition. The care plan was revised on 12/9/25, by Registered Assessment Coordinator (RNAC), Employee E12 with interventions that included confer with physician about wound progress or lack of each week during weekly wound rounds. Review of progress note dated 12/7/25, indicated the resident arrived at facility. A deep tissue injury (DTI- a type of pressure-induced tissue damage that begins beneath the skin, often over bony prominences, and can develop into serious wounds if not recognized early) was observed to the resident's left heel. No measurements were obtained. Review of Resident R5's physician progress note dated 12/8/25, failed to include evidence the physician assessed or evaluated the resident's left heel deep tissue injury or skin. The physician failed to provide physician oversight and supervise Resident R5's wound care and treatment. Review of Resident R5's Minimum Data Set (MDS, periodic assessment of resident care needs) dated 1/20/26, indicated the diagnoses were current. Review of Section M: Skin Conditions indicated the resident was not at risk for developing pressure ulcers. It was revealed the resident had one unstageable deep tissue injury that was present upon admission/reentry. Review of Resident R5's physician orders from 1/7/26, to 1/26/26, failed to include an order to apply skin prep (or similar protective barrier film) to bilateral heels. Review of Resident R5's wound assessment dated [DATE], indicated the resident developed a right heel stage three pressure ulcer that was not present on admission/reentry. The pressure ulcer measure 1.2 centimeters (cm) x 1.4 cm with light bloody exudate. Review of Resident R5's clinical record failed to include an order for the resident's right heel stage three pressure ulcer for 1/26/26, and 1/27/26. Review of Resident R5's wound care assessment dated [DATE], completed by CRNP, Employee E8 revealed the resident had a right heel unstageable pressure injury (occurs when prolonged pressure, often over bony prominences such as the heels, sacrum, hips, or tailbone, causes localized tissue damage and necrosis, but the true depth of the wound is obscured by dead tissue or other coverings). The measurements were 4.7 cm x 3.2 cm. Small amount of sero-sanguineous drainage (a type of wound exudate that is a mixture of serous (a type of fluid that comes out of a wound with tissue damage) fluid and small amounts of blood was noted. Treatment orders included to cleanse right heel with normal saline (a sterile solution used primarily for wound irrigation and cleansing), apply xeroform (a sterile, non-adherent petrolatum gauze dressing containing microbial agents, used to protect wounds and promote moist healing while reducing infection risk) cover with dry clean dressing daily, and change as needed. It was documented the plan of care and education was discussed with facility staff. The wound increased in size. Review of Resident R5's physician orders from 1/28/26, to 2/4/26, failed to include an order to cleanse right heel with normal saline, apply xeroform, cover with dry clean dressing daily, and change as needed. The facility failed to follow wound care orders and treatment. Review of Resident R5's physician progress note dated 2/3/26, failed to include evidence the physician evaluated or assessed the resident's right heel wound or skin. The physician failed to provide physician oversight and supervise (continued on next page)		

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident R5's wound care and treatment. Review of Resident R5's wound care assessment dated [DATE], completed by CRNP, Employee E8 revealed the resident's right heel had copious amounts of green drainage. The wound measure 5.7 cm x 5.4 cm. The wound was deteriorating. The peri wound skin presents with signs and symptoms of infection. A wound culture, and an x-ray was ordered. Review of Resident R5's progress note dated 2/4/26, revealed the resident was observed on wound rounds. Serous drainage noted to right heel wound. New orders for wound culture, right foot x-ray, right foot venous doppler. Testing ordered through express mobile, heel wound culture obtained. Resident placed in enhanced barrier precautions (EBP). Review of Resident R5's wound culture results dated 2/7/26, revealed there were heavy growth of pseudomonas aeruginosa (a bacteria that can cause infections). Review of Resident R5's clinical record from 12/8/25, to 2/7/26, failed to include evidence the physician supervised care in a timely manner for Resident R5's wound care and treatment. During an interview on 7/17/26, at 11:56 a.m. the Assistant Director of Nursing (ADON) Employee E1, confirmed the facility failed to ensure that a physician supervised care in a timely manner for one of 12 sampled resident (Resident R5). 28 Pa. code 211.2(d)(3) Medical director.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and staff interviews, it was determined that the facility failed to ensure Medication Regimen Reviews (MRR) were completed by the facility for two of six residents (Resident R48 and R72). Findings include: Review of the facility policy Resident Medication Regimen Review last reviewed 5/28/26, indicated pharmacists will review all charts in accordance with the standard established by the American Society of Consult Pharmacist in accordance with state and federal recommendations. The goal of this review is to promote positive outcomes and minimize adverse consequences associated with medication; the review includes preventing, identifying, reporting and resolving medication related problems, medication errors. or other irregularities and collaborating with other members of the Interdisciplinary Team (IDT). Review of admission record indicated Resident R48 was admitted to the facility on [DATE]. Review of Resident R48's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/4/26, indicated the diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain), and depression. Review of Resident R48's MRR dated 6/10/26, indicated the following recommendation from the pharmacist to the physician: Can we safely add Jardiance (medication used to treat high blood sugars) 10 milligrams daily to optimize residents' diabetes? Recommendation: Review of Resident R48's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 6/10/26. On 6/27/25, a Physician Assistant (PA) addressed the MRR, stating, Jardiance added. Review of Resident R48's MRR dated 1/15/26, indicated the following recommendation from the pharmacist to the physician: Based on resident's blood sugars, please consider a dose increase in Metformin (a medication used to treat high blood sugar) for better control. Recommendation: Review of Resident R48's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 1/15/26. On 1/21/26, a PA addressed the MRR, stating, Check labs on 1/27/26 then will evaluate Metformin. During an interview on 7/17/26, at 9:26 a.m. the Assistant Director of Nursing Employee E1 confirmed the above findings and that the facility failed to provide documentation that medication regimen reviews (MRR) were completed and reviewed by the resident's attending physician monthly for Resident R48. (continued on next page)		

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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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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R72's clinical record indicated an admission date of 9/23/25. Review of Resident R72's MDS dated [DATE], indicated the diagnosis of hypertension (high blood pressure), diabetes, and anxiety. Review of Resident R72's MMR dated 5/12/26, indicated the following: Second request: At the psychiatric (psych) IDT meeting held on 4/15/26, staff mentioned that Resident R72 is anxious despite treatment with Buspar. Resident R72 is due for a psych follow up evaluation. Please refer to psych (last seen 10/21/25) to evaluate if Resident R72 may benefit from additional psych medications to help treat her anxiety/possible depression. Review of Resident R72's clinical record failed to include documentation that Resident R72 completed a psych evaluation. Review of Resident R72's MRR dated 6/4/26, indicated the following: Third request: At the psych IDT meeting held on 4/15/26, staff mentioned that Resident R72 is anxious despite treatment with Buspar. Resident R72 is due for a psych follow up evaluation. Please refer to psych (last seen 10/21/25) to evaluate if Resident R72 may benefit from additional psych medications to help treat her anxiety/possible depression. Review of Resident R72's clinical record failed to include documentation that Resident R72 completed a psych evaluation. During an interview completed on 7/17/26, at 2:20 p.m. the Assistant Director of Nursing Employee E1 confirmed that the MMRs were not followed up with the Psych recommendations for Resident R72 and that facility failed to ensure Medication Reviews were completed by the facility for Resident R72. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.9 (k) Pharmacy services.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly store medications in two of three medication carts (9 East Medication Cart and 10 East Medication Cart) and in one of two medication rooms (3 East Medication Room). Findings include: Review of the facility policy Medication Administration General Guidelines last reviewed 5/28/26, indicated to provide direction in the safe and effective administration of medications, including preparation and technique to store and handle medications in accordance with manufacture recommendations and/or stated and federal requirements. Checks for documentation of date opened on applicable medications. Checks both the manufacture expiration date and the date opened for multidose vials. Review of the facility policy Medication Distribution System last reviewed 5/28/26, indicated medications and biologicals are stored safely, securely, and properly. Appropriate labeling of all medication orders to assist in providing safe, effective administration. The pharmacy provider dispenses medications that meet legal requirements of good manufacturing practices. Medications are stored and kept in these containers. During a medication cart observation completed on 7/13/26, at 12:40 p.m. the 9 East Medication Cart contained the following: 2 bottles of gental eye drops opened and failed to be labeled with a date as required. 2 bottles of refresh tears eye drops opened and failed to be labeled with a date as required. 2 ipratropium bromide nasal inhalers opened and failed to be labeled with a date as required. 1 calcitonin nasal spray opened and failed to be labeled with a date as required. 1 vial Lispro insulin opened and failed to be labeled with a date as required. 1 vial Novolog insulin opened and failed to be labeled with a date as required. 1 nasal decongestion spray opened and failed to be labeled with a date as required. 1 bottle lactulose liquid opened and failed to be labeled with a date as required. During an interview completed on 7/13/26, at 12:52 p.m. Licensed Practical Nurse (LPN) Employee E3 confirmed the above observations and that the facility failed to properly store medications in the 9 East Medication Cart. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medication cart observation completed on 7/15/26, at 12:34 p.m. the 10 East Medication Cart contained the following: 1 bottle of Peridex mouth rinse opened and failed to be labeled with a date as required. 1 bottle of Celexa liquid opened and failed to be labeled with a date as required. 1 bottle Robitussin liquid opened and failed to be labeled with a date as required. 2 bottles of lactulose liquid opened and failed to be labeled with a date as required. 2 bottles of refresh tears opened and failed to be labeled with a date as required. 2 Flonase nasal sprays opened and failed to be labeled with a date as required. 3 Anoro Ellipta inhalers opened and failed to be labeled with a date as required. 1 bottle Lumigan eye drops opened and failed to be labeled with a date as required. 1 bottle latanoprost eye drop opened and failed to be labeled with a date as required. 1 bottle of ipratropium nasal spray opened and failed to be labeled with a date as required. 1 bottle liquid senna opened and failed to be labeled with a date as required. 2 bottles of Flonase nasal spray opened and failed to be labeled with a date as required. 1 bottle of Pataday eye drops opened and failed to be labeled with a date opened as required. 1 Advair discus inhaler not labeled with a resident identifier, not stored in box or bag and failed to be labeled with an opened date as required. During an interview completed on 7/15/26, at 12:45 p.m. LPN Employee E4 confirmed the above observations and that the facility failed to properly store medications in the 10 East Medication Cart. During a medication room observation on 3 East on 7/15/26, at 11:01 a.m. the following were observed: Turberculin (used to detect respiratory disease) vial opened and was not dated with an open date or an expiration date. During an interview on 7/15/26, at 11:16 a.m. Assistant Director of Nursing Employee E1 confirmed the above and that the facility failed to properly store medications in one of two medication rooms (3 East Medication Room). (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.9(a)(1) Pharmacy services. 28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policy, payor source data, and resident and staff interview, it was determined the facility failed to ensure timely and necessary dental services for one resident who is a Medicaid recipient (Resident R5) out of three residents reviewed. Findings include: Review of facility Oral Hygiene-Dental Services last reviewed 5/28/26, indicated it is the facility's policy to ensure resident oral hygiene needs are adequately met. Prothesis included but not limited to dentures, partial plates, and dental bridges. The facility will assume the responsibility of replacing dentures when it is determined through investigation that loss/damage were caused by facility. Review of the clinical record revealed that Resident R5 was admitted to the facility on [DATE], and readmitted [DATE], with diagnoses of muscle weakness, muscle wasting and atrophy, and Parkinson's Disease (neuromuscular disorder causing tremors and difficulty walking). Review of Resident R5's care plan initiated 1/29/25, indicated to monitor for difficulty chewing and swallowing and to consult dental clinic as needed. Review of Resident R5's clinical record revealed on 8/19/25, revealed the resident was evaluated by the dentist. The resident's upper and lower dentures were delivered, check fit and occlusion and adjusted. Pt. faces two major challenges, has very dry mouth and a very low upper anterior muscle attachment which tends to dislodge the denture-it was reduced but patient will still likely need adhesive to make denture work. Will follow up at next visit with upper and lower complete dentures. Review of Resident R5's Minimum Data Set (MDS, periodic assessment of resident care needs) dated 1/20/26, indicated the diagnoses were current. Review of Section L0200. Dental indicated the resident did not have the following: broken or loosely fitting full or partial dentures, no natural teeth or tooth fragments, abnormal mouth tissues, obvious or likely cavity or broken natural teeth. Review of Resident R5's clinical record revealed on 4/7/26, the resident was evaluated by the dentist. Resident R5 was completely edentulous (lacking teeth) with lower complete denture only. Resident is missing the upper and if it cannot be found is interested in a new one. Resident complains of sore spots on the lower. When patient is eligible, begin new upper complete denture. Review of progress note dated 6/25/26, indicated family reported that she needs new upper and lower dentures. She was seen in Dental Clinic in May. They consult indicated that she will get new dentures when eligible. During an interview and observation on 7/13/26, at 2:20 p.m. Resident R5 was observed to have no teeth or dentures in mouth. Resident R5's spouse stated the resident received a new set of dentures, however they came up missing. It was indicated Resident R5's mentioned the concern for Resident R5's dentures at the last care conference and the facility indicated they would get it straightened out. During an interview on 7/16/26, at 12:30 p.m. the Assistant Director of Nursing Employee E1 stated the facility staff is aware Resident R5 needs their dentures replaced. It was indicated she was not eligible yet. During an interview on 7/16/26, at 1:00 p.m. Nursing Home Administrator confirmed the facility failed to provide prompt dental services for one resident who is a Medicaid recipient (Resident R5) out of three residents reviewed. 28 Pa Code 211.12 (c)(d)(3)(5) Nursing services. 28 Pa Code 211.10 (c) Resident care policies.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to prepare food in a form to meet physician ordered diets for one of eleven residents reviewed (Resident R25). Findings include: Review of the clinical record indicated Resident R25 was admitted to the facility on [DATE], with diagnoses of high blood pressure, stroke, and anxiety. Review of Resident R25's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/9/26, indicated the diagnoses were current. Review of Resident R25's care plan dated 7/6/26, indicated to provide the resident with a soft chopped diet with extra sauce/gravy. Interventions included to adjust diet orders to promote appropriate nutritional status as indicated by diagnoses and physical condition. Clinical record review for Resident R25 revealed an active physician's order dated 7/6/26, to provide a soft chopped diet with extra sauce and gravy. Observation of the lunch meal on 7/13/26, at 11:58 a.m. revealed Resident R25's meal tray included an entree with meat that was not chopped. Review of Resident R25's meal tray ticket indicated Salisbury steak was to be served soft chopped with extra gravy. During an interview on 7/13/26, at 12:00 p.m. Nurse Aide Employee E21 confirmed Resident R25's meat was not chopped and the facility failed to serve food in it's ordered form. The surveyor reviewed the above dietary concerns for Resident R25 during an interview with the Nursing Home Administrator and the Director of Nursing on 7/14/26, at approximately 3:00 p.m. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job descriptions, clinical records and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility when it was determined that the facility had extensive noncompliance in multiple areas of pressure ulcer care, which resulted in the development of avoidable Stage III or Stage IV pressure ulcers for two of two residents (Resident R5 and Resident R13), resulting in an infection for one of two residents (Resident R5). This failure resulted in an immediate jeopardy. Findings include: The signed job description for Nursing Home Administrator, dated 5/18/26, specified the primary purpose of the job position is to lead, guide, and direct the operations of the facility in accordance with local, state, and federal regulations, standards, and established facility policies and procedures to provide appropriate care and services to residents and patients. The signed job description for the Director of Nursing, dated 3/22/26, specified the purpose of the job is to plan, organize, develop and direct the overall operation of the Nursing Department in accordance with Professional Nursing Law, and current federal, state, and local standards, guidelines, and regulations that govern the facility, and under the direction of the Regional Center Administrator. Based on findings identified in this report, the facility failed to effectively manage the facility to make certain that residents received proper preventative wound care, and treatments for wound care, which resulted in the development of avoidable Stage III or Stage IV pressure ulcer for two of two residents (Resident R5 and Resident R13), resulting in an infection for one of two residents (Resident R5). This failure resulted in an immediate jeopardy. During an interview on 7/18/26, at 3:30 p.m. the NHA, and DON were notified that they failed to effectively manage the facility to make certain that residents received proper preventative wound care, and treatments for wound care, which resulted in the development of avoidable Stage III or Stage IV pressure ulcers, and a wound infection. This failure resulted in an immediate jeopardy. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(3)(e)(1) Management.		

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on review of facility documents, and staff interview, it was determined that the facility failed to provide training on Effective Communication for one of eight staff members (nurse aide (NA) Employee E27).Findings include: Review of NA Employee E27's personnel file indicated a hire date of 6/1/24, and failed to include Effective Communication training between 6/1/24, and 6/1/25. During an interview on 7/18/26, at 9:50 a.m. Human Resources Employee E29 confirmed that the facility failed to provide training on Effective Communication for one of eight staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a) Staff Development.		

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on review of facility documents, and staff interview, it was determined that the facility failed to provide training on the Quality Assurance and Performance Improvement (QAPI) program for one of eight staff members (nurse aide (NA) Employee E27). Findings include: Review of NA Employee E27's personnel file indicated a hire date of 6/1/24, and failed to include QAPI program training between 6/1/24, and 6/1/25. During an interview on 7/18/26, at 9:50 a.m. Human Resources Employee E29 confirmed that the facility failed to provide training on QAPI program for one of eight staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a) Staff development.		

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on review of facility documents, and staff interview, it was determined that the facility failed to provide training on Compliance and Ethics for one of one of eight staff members (nurse aide (NA) Employee E27). Findings include: Review of NA Employee E27's personnel file indicated a hire date of 6/1/24, and failed to include Compliance and Ethics training between 6/1/24, and 6/1/25. During an interview on 7/18/26, at 9:50 a.m. Human Resources Employee E29 confirmed that the facility failed to provide training on Compliance and Ethics for one of eight staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a) Staff development.		

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observations and staff interview, it was determined that the facility failed to post complete contact information for as required for the Office of the State Long-Term Care Ombudsman program, and Medicaid Fraud Unit, and failed to post a statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation on three of three floors (First, Second, and Third Floors). Findings include: During observations, and interview completed on 7/17/26, at 9:50 a.m. Case Work Supervisor E18 confirmed that the facility failed to post email addresses of the Office of the State Long-Term Care Ombudsman program, and Medicaid Fraud Unit, and a statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation on three of three floors (First, Second, and Third Floors) as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(e) Management.		