STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395617	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John J Kane Regional Center-SC	300 Kane Boulevard Pittsburgh, PA 15243

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical and facility record review, facility submitted documents, and staff interviews, it was determined that the facility failed to provide adequate supervision to prevent elopement for one of 41 residents (Resident R1). Review of the facility policy Elopement - Missing Resident dated 1/8/25, indicated the facility will provide to each resident adequate monitoring and interventions to maintain safety. Review of the clinical record revealed Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 6/30/25, included diagnoses of Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior) and a seizure disorder. Review of Section E: Behavior indicated Resident R1 had displayed wandering behaviors. Review of an Elopement Evaluation completed on 6/18/25, indicated Resident R1 was at risk for elopement. Review of the physician's order dated 6/18/25, indicated Resident R1 was ordered a security bracelet that alerts when an identified resident approaches a monitored door. Review of Resident R1's plan of care for Risk for Elopement initiated 6/18/25, indicated Resident R1 is at risk for elopement due to Alzheimer's disease and a history of wandering. Review of a progress note dated 7/7/25, at 8:43 a.m. indicated Resident R1 was testing door handles and keypads. When lobby door is open, she will start to run for the door. Review of a progress note dated 7/10/25, at 12:59 p.m. indicated Resident R1 was trying to open dining room windows this morning. Any time there is an open door and she notices, she will sprint towards it. Review of a progress note dated 7/15/25, at 11:18 p.m. indicated, At 7:13 p.m. resident was found on the 2nd floor walking up the middle hall from the stairwell. Nursing supervisor notified by security that the resident had gotten out of the locked unit. Upon investigation it was found that the maglocks (electrified magnetic locking mechanism) on the stairwell doors were not engaged due to planned power outage. Resident returned to locked unit without difficulty. Resident had no injury of any kind, did not fall or hurt herself in any way. No s/s (signs or symptoms) of emotional distress upon return to unit. Review of facility submitted information dated 7/16/25, indicated that on 7/15/25, At 7:11pm, During a scheduled facility power outage, the maglock door batteries became disengaged. While monitoring CCTV (closed-circuit television, a type of video surveillance system), Security saw resident enter the stairwell on unit 4A. Resident was identified as [Resident R1]. Security witnessed on camera her carefully safely walk down the stairwell and exit on unit 2A. Total Time 2 mins and 20 seconds. Nursing Supervisor immediately notified by Security and met resident on unit 2A. Resident returned to the unit safely. Resident had no injury. No emotional distress noted. MD (Doctor of Medicine) and NOK (next of kin) notified. During an interview on 7/17/25, at approximately 1:00 p.m. the Assistant Director of Nursing confirmed the facility failed to provide adequate supervision to prevent elopement for one of 41 residents (Resident R1).

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on facility document review and staff interviews, it was determined that the facility failed to ensure that essential equipment was in safe operating condition on five of five nursing units (2A, 3A, 3B, 4A, and 4B). Review of facility submitted information dated 7/16/25, indicated that on 7/15/25, At 7:11pm, During a scheduled facility power outage, the maglock (electrified magnetic locking mechanism) door batteries became disengaged. While monitoring CCTV (closed-circuit television, a type of video surveillance system), Security saw resident enter the stairwell on unit 4A. Resident was identified as [Resident R1]. Security witnessed on camera her carefully safely walk down the stairwell and exit on unit 2A. Total Time 2 mins and 20 seconds. Nursing Supervisor immediately notified by Security and met resident on unit 2A. Resident returned to the unit safely. Resident had no injury. No emotional distress noted. MD (Doctor of Medicine) and NOK (next of kin) notified. Review of an employee statement dated 7/15/25, written by Security Employee E1, indicated, While reviewing CCTV I noticed a resident enter the stairwell 1 entry on 4A. She was identified as [Resident R1]. I witnessed her walk down the stairwell and exit on 2A middle hall. She walked to the nurses station. I then called [Employee E2] and she and [Employee E3] responded to 2A and addressed it. She was returned to her unit right away. Subsequently upon further investigation the maglocks failed during the planned power outage. Review of an employee statement dated 7/15/25, written by Security Director Employee E4 indicated, At 1930 hrs (7:30 p.m.) on the above date (7/15/25) during a scheduled facility wide power shutdown, I received a call from Security Employee E1 reporting that a resident identified as [Resident R1] had entered stairwell #1 from unit 4A proceeding down to unit 2A. Security Employee E1 stated that the house supervisor was immediately notified of the incident. The resident was assessed by staff and returned to the unit. Under my direction, Security Employee E1 was instructed to check all maglocks on all stairwells, as an extra precaution all mechanical alarm boxes were to be tested and engaged. I advised Security Employee E1 that I was responding to the facility with a 20-30 min ETA (estimated time of arrival). Upon my arrival at 8pm Security Employee E1 informed me that all nursing unit maglocks were down. Nursing had placed a staff member at each door as an extra precaution. Upon investigation found that the battery backups for these doors had failed. Further investigation showed that the power supplies for these doors were not on generator power. ESM (Environmental Service Manager) Employee E5 was notified of the issue. Upon Employee E5's direction the facility electrician [Maintenance Employee E6] rewired the power supplied to a generator electric panel, restoring power to the affected doors at 2130 hrs (9:30 p.m.). the A side maglocks were fully functional. I made a sweep of the A side of the facilty and confirmed that all A side maglocks were again operating as designed. At 2230 (10:30 p.m.) power was restored to all B side maglocks. I again made a sweep of the B side to confirm all doors were working as designed. Upon review of the guard log book these doors were last tested at 1530 hrs (3:30 p.m.) and fully functional. I departed the facility at 2230 hrs (10:30 p.m.). All doors were fully functional. Review of a statement written by Environmental Service Manager Employee E5 stated that:7/15/25, (approximate times):8:00 a.m.: with Electric Maintenance Vendor V1 and V2 onsite, the local power provider terminated outside power and the facility converted to generator power. 4:00 - 4:30 p.m.: Electric Maintenance Vendor V2 advised that the Main Transfer Switch was faulty. At that time Facility Executive Employee E7, Director of Facilities Employee E8, and the County Electrician Employee E9 were contacted about the failed switch and the need to replace it immediately. 5:00 p.m. - Electric Vendor V2 was able to find a replacement switch, located approximately 90 miles away. The part was picked up and delivered at 8:00 p.m. Installation was begun at that time. 8:00 p. m. - Security Employee E1 notified that the maglock doors had failed and a resident got out of 4A. Battery backups were found to be low on power, and replace with new batteries. The decision was made change the maglocks from battery backup to generator power. 10:30 p.m. - All power to the maglock doors on the resident units was converted to generator emergency power. 7/16/25, (approximate times):12:00 a.m. - Electric Maintenance Vendor V2 completed the installation of the replacement part. The local power provider was called to restore service. The local power provider would not send anyone to restore power, due to confusion regarding the work order, with a work order from a sister facility. 2:00 a.m. - Power was restored by the local power provider. 7/17/25:Confirmed that all resident and non-resident area maglocks have backup generator power supply. During an interview on 7/17/25, at approximately 10:40 a.m. ESM Employee E5 confirmed that the facility had been unprepared for the maglock batteries to become too low on power during an extended power outage, and had not planned to have replacements used prior to the batteries