

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER John J Kane Regional Center-SC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on review of facility policy, Pennsylvania Code Title 49. Professional and Vocational Standards, clinical records, and facility documentation, and staff interview, it was determined that the facility failed to follow nursing standards of practice for safe medication administration for one of eight residents reviewed for medication administration (Resident R1). Findings include: Review of the Facility Policy, Medication Administration General Guidelines dated 2/1/26, indicated it is the policy to safely administer medications to residents as prescribed by the practitioner and in accordance with current standards of practice and regulatory requirements. Review of the facility policy Medication Error Reporting, Analysis and Correction (MERF) indicates a medication error is observed or identified preparation or administration of medication or biological which is not in accordance with practitioner orders, manufactures specification, and accepted professional standards and principles. Review of the Pennsylvania Code Title 49. Professional and Vocational Standards Chapter 21, State Board of Nursing: A. Registered Nurses (RN), revealed the following: 21.11 General Functions (a)(4) Carries out nursing care and actions which promote, maintain and restore the well-being of individuals. (d) The Board recognizes standards of practice and professional codes of behavior, as developed by appropriate nursing associations, as the criteria for assuring safe and effective practice. 21.14 Administration of Drugs (a) A licensed registered nurse may administer a drug ordered for a patient in the dosage and manner prescribed. Review of the facility Registered Nurse job description Duties and Responsibilities 28. Indicated the RN accurately carries out physician orders per facility nursing policies and procedures, transcribes and administers medications, treatments, and therapies. Review of facility personnel records on 6/16/26, indicated Registered Nurse (RN) Employee E1 is issued an active Pennsylvania State License in good standing. Review of Resident R1's clinical record indicated an admission date of 10/2/24, with diagnoses that included dementia, left hip replacement, high blood pressure, diabetes, asthma, and osteoporosis. Review of the Minimum Data Set (MDS) resident assessment and care screening dated 3/5/26, indicated Resident R1 is cognitively impaired with confusion at baseline. Review of nurse progress notes dated 5/22/26, indicated Resident R1 took another resident's medications v.s.s. (vital signs stable) no noted adverse effects at this time, however, will be sent to the hospital to be monitored. 911 called and transported. Review of a practitioner note dated 5/22/26, indicated able to review medications that patient grabbed and took with risk of hypotension (low blood pressure), hypoglycemia (low blood sugar), lethargy, delirium, bleeding. Will send to ER (emergency room) for evaluation and treatment. Review of a physician note dated 5/23/26, indicated Resident R1 was sent to the ER for evaluation after taking another patient's medication. Patient was clinically stable and had no complaints. The patient returned to facility after 24-hour review. Review of a facility Event Report Medication Error document dated 5/22/26, indicated Resident R1 took another resident's medication to include amlodipine (lowers blood pressure) 10 mg (milligrams), atenolol (lowers blood pressure and heart rate) 50 mg, Eliquis (blood thinner) 5 mg, Jardiance (antidiabetic) 12.5 mg, Lisinopril (antihypertensive) 20 mg, olanzapine (antipsychotic) 2.5 mg, Lexapro (antidepressant) 10 mg, Ativan (anti-anxiety medication) 0.5 mg, (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395617
		If continuation sheet Page 1 of 2

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	metformin (anti diabetic) 500 mg, Certavite (a supplement) and Zyrtec (antihistamine). The RN put another resident's medications in a med cup on a breakfast tray. The breakfast tray was then put in front of Resident R1, and she took the other resident's medications. Review of RN Employee E1's witness statement dated 5/22/26, indicated pulled patient 1's medication and placed it on a tray that is used to pass other trays. I went to assist another patient and when I returned the NA (nursing assistant) informed me that she (pt 2) (Resident R1) had taken the medication on the tray. Review of Resident R1's hospital Service and Length of Stay documentation dated 5/23/26, indicated the patient was admitted for accidental medication error. The resident was monitored and remained stable. Resident R1 returned to the facility on 5/23/26 in stable condition. During an interview on 6/16/26, at approximately 10:00 a.m. the Nursing Home Administrator and the Director of Nursing confirmed that RN Employee E1 failed to follow nursing standards of practice for safe medication administration for Resident R1. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services		