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 09/26/2024
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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31343 Based on review of facility policy, resident clinical records, documentation provided by the facility, facility investigation, resident interview, and staff interviews, it was determined that the facility failed to ensure that a resident was free from neglect, which resulted in actual harm as evidenced by a left distal femur (thigh bone closest to the knee bone) fracture for one of three residents (Resident R91) and a head injury for one of three residents (Resident R3). Findings include: Review of the facility policy Abuse- Resident last reviewed on 1/5/24, indicated that the facility treat every resident with respect and dignity. The failure of the facility to provide goods and services to a resident that are necessary to avoid or may result in physical harm is identified as neglect. All complaints/allegations of resident abuse/neglect shall be promptly reported to the administration and investigated. Alleged violations whether or not confirmed, must be reported. Review of the clinical record indicated Resident R91 was admitted to the facility on [DATE], with diagnoses which included right sided (dominant side) hemiplegia and hemiparesis (paralysis of one side of body) due to a stroke, morbid obesity and difficulty swallowing. An Minimum Data Set (MDS - a periodic assessment of resident care needs) dated 7/13/24, indicated the diagnoses remained current, Section GG 0170 Mobility identified Resident R91 as dependent (which requiring one staff to do all the effort or two staff) for bed mobility. Review of an incident report dated 7/30/24, at 12:30 a.m., indicated that Resident R91 was being provided incontinence care by Nurse Aide (NA) Employee E9 and redness was identified on Resident R91's buttocks. The statement further indicated NA Employee E9 turned away from Resident R91 to get cream and Resident R91 slid off of the bed (away from NA Employee E9) and onto the floor causing a fractured left distal femur. Review of the statement that was attached to the investigation dated 7/30/24, from NA Employee E9 stated that I came into the room and Resident R91 told me she needed to be changed. As I am changing her brief and wiping her backside, I noticed redness in the area I asked her did she have any cream her response was yes, I asked her where was it she told me as I turned my left side to grab the cream she started to roll herself out of bed. I ran over to the other side of bed and sat with her until the ambulance came. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility investigation dated 7/31/24, contained the Staff Development Referral process dated 12/28/22, that was signed by NA Employee E9. This document includes the statement for resident bed mobility: Residents to be rolled towards you, not away from you (two staff members present when indicated on the assignment sheet). During an interview on 9/23/24, at 1:00 p.m., Resident R91 stated that she recalled the event that resulted in this fall and injury. Resident R91 reported she was rolled away from NA Employee E9 onto her right side that has limited mobility, and she verbalized I am sliding a couple of times before she fell out of the bed. Resident R91 stated the bed was raised to a higher position so that NA Employee E9 could provide care, as Resident R91 tried to reach out with her left arm to stop the slide there was nothing within reach and she fell . During an interview on 9/23/24, at 1:10 p.m., Resident R91's roommate Resident R125 confirmed the details of Resident R91's detail of the fall. During an interview on 9/25/24, at 1:30 p.m. with NA Employee E10, indicated that resident care is identified on the care sheets received at the start of the shift. Employee E10 indicated report is received between shifts for any changes to the resident's care. Employee E10 indicated additional staff is available to assist when requested. Employee E10 indicated the facility policy is to roll a resident toward staff when providing care. During an interview on 9/25/24, at 1:45 p.m. with NA Employee E11, indicated that resident care is identified on the care sheets received at the start of the shift. Employee E11 indicated report is received between shifts for any changes to the resident's care. Employee E11 indicated additional staff is available to assist when requested. Employee E11 indicated Resident R91 had been an assist of one and now is requires two. Employee E11 indicated the facility policy is to roll a resident toward staff when providing care. During an interview on 9/25/24, at 2:00 p.m. with NA Employee E12, indicated that resident care is identified on the care sheets received at the start of the shift. Employee E12 indicated report is received between shifts for any changes to the resident's care. Employee E12 indicated additional staff is available to assist when requested. Employee E12 indicated the facility policy is to roll a resident toward staff when providing care. During an interview on 9/26/24, at 10:22 a.m., the Director of Nursing confirmed NA Employee E9 rolled Resident R91 away from her to provide care then turned away from Resident R91 during this care not providing actual positioning assistance which resulted in actual harm for Resident R91 when a fractured left distal femur was sustained. Review of the clinical record indicated that Resident R3 was admitted to the facility on [DATE], with diagnoses which included anoxic brain injury, quadriplegia, schizoaffective disorder, contractures, anxiety, blindness and dementia. A MDS dated [DATE], indicated the diagnoses remained current, Section GG 0170 Mobility indicated functional abilities of the resident identified Resident R3 required dependent care with rolling left to right which is indicated the helper does all the effort or two staff are required. (continued on next page)

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	09/26/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident R3's physican orders dated 10/31/23, prior to the incident and remained current, indicated Resident R3 required bed mobility of assist of two. Resident R3 has no use of his hands or arms due to brain injury and contractures. Review of Resident R3's plan of care, prior to incident and remained current, indicated Resident R3 had behaviors of resistant with care. Review of an incident report dated 8/28/24, indicated that Resident R3 developed a 1.5 c.m. x 2.0 c.m. x 0.1 c.m. head laceration with a bruise requiring steri strips (tape that is used in place of sutures) to close when NA Employee E8 attempted to readjust a sheet around his waist to keep him from picking at his brief with no additional assistance when turning Resident R3 who cannot hold himself or stop himself from rolling, NA Employee E8 hit Resident R3s head off of the overbed table causing the laceration. During an interview on 9/25/24, at 8:15 a.m., NA Employee E5 stated that Resident R3 is rigid and required two staff since he becomes combative with care. NA Employee E5 stated that he frequently is assigned to Resident R3. The Nurse Aides use a care sheet but they also get report between shifts in case there are any changes to determine the assistance required by the residents. During an interview on 9/25/24, at 8:40 with NA Employee E6 and E7 indicated that resident care is identified on the care sheets but they also get report between shifts in case there are any changes. During an interview on 9/26/24, at 10:22 a.m., the Director of Nursing confirmed that the facility failed to make certain that a resident was free from neglect, which resulted in actual harm as evidenced by a left distal femur (thigh bone closest to the knee bone) fracture for one of three residents (Resident R91) and a head injury for one of three residents (Resident R3). 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 201.29(a)(c)(d)(j) Resident Rights. 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(1)(3) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 31343

Based on review of facility policy, review of facility incident/accident reports, clinical records, and staff interviews, it was determined that the facility failed to identify and/or investigate potential abuse and/or neglect for one of three residents (Resident R3).

Findings include:

Review of the facility policy Abuse- Resident last reviewed on 1/5/24, indicated that the facility treat every resident with respect and dignity. The failure of the facility to provide goods and services to a resident that are necessary to avoid or may result in physical harm is identified as neglect. All complaints/allegations of resident abuse/neglect shall be promptly reported to the administration and investigated. Alleged violations whether or not confirmed, must be reported.

Review of the clinical record indicated that Resident R3 was admitted to the facility on [DATE], with diagnoses which included anoxic brain injury, quadriplegia, schizoaffective disorder, contractures, anxiety, blindness and dementia.

Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 6/18/24, indicated the diagnoses remained current. Section GG 0170 Mobility indicated functional abilities of the resident identified resident R3 required dependent care with rolling left to right which is indicated the helper does all the effort or two staff are required.

Review of Resident R3's physican orders dated 10/31/23, prior to the incident and still current, indicated Resident R3 required bed mobility of assist of two.

Review of Resident R3 plan of care, prior to incident and current, indicated resident R3 had behaviors of resistant with care.

Review of an incident report dated 8/28/24, indicated that Resident R3 developed a 1.5 c.m. x 2.0 c.m. x 0.1 c.m. head laceration with a bruise requiring steri strips (tape that is used in place of sutures) to close when NA Employee E8 attempted to readjust a sheet around his waist to keep him from picking at his brief with no additional assistance when turning Resident R3 who cannot hold himself or stop himself from rolling, NA Employee E8 hit Resident R3s head off of the overbed table causing the laceration.

During an interview on 9/25/24, at 8:15 a.m., NA Employee E5 stated that Resident R3 is rigid and required two staff since he becomes combative with care. NA Employee E5 stated that he frequently is assigned to Resident R3.

During an interview on 9/25/24, at 8:40 with NA Employee E6 and E7 indicated that resident care is identified on the care sheets (a sheet shown to the surveyor and is on each nursing unit as a quick reference for each residents care needs for the nurse aides to utilize) but they also get report between shifts in case there are any changes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/26/24, at 10:22 a.m., the Director of Nursing confirmed that the facility failed to identify and/or investigate potential abuse and/or neglect for one of three residents (Resident R3). 28 Pa Code: 201.14(a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1)(3) Management. 28 Pa Code: 211.10 (d) Resident care policies. 28 Pa Code: 211.12 (d)(3) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31343 Based on a review of facility policy, clinical records, facility documents, and staff interviews, it was determined that the facility failed to provide appropriate assistance to prevent falls and an injury, resulting in actual harm of a leg fracture for one of three residents reviewed (Resident R91) and a head laceration for one of three residents (Resident R3). Findings include: Review of the facility policy All Policy and Procedure: General Guidelines last reviewed on 1/5/24, indicated that the facility will provide necessary care and services to each resident to attain or maintain his/her highest practicable physical, mental and psychosocial well-being. Staff must properly position the resident [NAME] position of comfort during and after any procedure. All care and services must be provided a prescribed by the practitioner, and according to the resident's person-centered plan of care. Review of the facility policy Fall Risk Evaluation Policy last reviewed on 1/5/24, indicated that residents who are identified as at risk for falls are provided safety measures that would deter falls and provide a safe environment. Review of the American Congress of Rehabilitation Medicine (ACRM) - Caregiver Guide and Instructions for Safe Bed Mobility published 4/28/17, indicated bed mobility refers to activities such as scooting in bed, rolling, side-lying to sitting, and sitting to lying down. Review of the clinical record indicated Resident R91 was admitted to the facility on [DATE], with diagnoses which included right sided (dominant side) hemiplegia and hemiparesis (paralysis of one side of body) due to a stroke, morbid obesity and difficulty swallowing. Review of the Minimum Data Set (MDS - a periodic assessment of resident care needs) dated 7/13/24, indicated the diagnoses remained current, Section GG 0170 Mobility identified Resident R91 as dependent (which requiring one staff to do all the effort or two staff) for bed mobility. Review of an incident report dated 7/30/24, at 12:30 a.m., indicated that Resident R91 was being provided incontinence care by Nurse Aide (NA) Employee E9 and redness was identified on Resident R91's buttocks. This report stated NA Employee E9 turned away from Resident R91 to get cream and Resident R91 slid off of the bed (away from NA Employee E9) and onto the floor causing a fractured left distal femur (thigh bone closest to the knee bone). Review of the statement that was attached to the investigation dated 7/30/24, from NA Employee E9 stated that I came into the room and Resident R91 told me she needed to be changed. As I am changing her brief and wiping her backside, I noticed redness in the area I asked her did she have any cream her response was yes, I asked her where was it she told me as I turned my left side to grab the cream she started to roll herself out of bed. I ran over to the other side of bed and sat with her until the ambulance came. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility investigation dated 7/31/24, contained the Staff Development Referral process dated 12/28/2022, that was signed by NA Employee E9. This document includes the statement for resident bed mobility: Residents to be rolled towards you, not away from you (2 staff members present when indicated on the assignment sheet). During an interview on 9/23/24, at 1:00 p.m., Resident R91 stated that she recalled the event that resulted in this fall and injury. Resident R91 reported she was rolled away from NA Employee E9 onto her right side that has limited mobility, and she verbalized I am sliding a couple of times before she fell out of the bed. Resident R91 stated the bed was raised to a higher position so that NA Employee E9 could provide care, as Resident R91 tried to reach out with her left arm to stop the slide there was nothing within reach and she fell . During an interview on 9/23/24, at 1:10 p. m., Resident R91's roommate Resident R125 confirmed the details of Resident R91's detail of the fall. During an interview on 9/25/24, at 1:30 p.m. with NA Employee E10, indicated that resident care is identified on the care sheets received at the start of the shift. Employee E10 indicated report is received between shifts for any changes to the resident's care. Employee E10 indicated additional staff is available to assist when requested. Employee E10 indicated the facility policy is to roll a resident toward staff when providing care. During an interview on 9/25/24, at 1:45 p.m. with NA Employee E11, indicated that resident care is identified on the care sheets received at the start of the shift. Employee E11 indicated report is received between shifts for any changes to the resident's care. Employee E11 indicated additional staff is available to assist when requested. Employee E11 indicated Resident R91 had been an assist of one and now is requires two. Employee E11 indicated the facility policy is to roll a resident toward staff when providing care. During an interview on 9/25/24, at 2:00 p.m. with NA Employee E12, indicated that resident care is identified on the care sheets received at the start of the shift. Employee E12 indicated report is received between shifts for any changes to the resident's care. Employee E12 indicated additional staff is available to assist when requested. Employee E12 indicated the facility policy is to roll a resident toward staff when providing care. During an interview on 9/26/24, at 10:22 a.m., the Director of Nursing confirmed NA Employee E9 rolled Resident R91 away from her to provide care then turned away from Resident R91 during this care causing the resident to roll out of bed which resulted in actual harm for Resident R91 when a fractured left distal femur was sustained. Review of the clinical record indicated that Resident R3 was admitted to the facility on [DATE], with diagnoses which included anoxic brain injury, quadriplegia, schizoaffective disorder, contractures, anxiety, blindness and dementia. A MDS dated [DATE], indicated the diagnoses remained current, Section GG 0170 Mobility indicated functional abilities of the resident identified resident R3 required dependent care with rolling left to right which is indicated the helper does all the effort or two staff are required. Review of Resident R3's Physican orders dated 10/31/23, prior to the incident and remained current, indicated Resident R3 required bed mobility of assist of two. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident R3 plan of care, prior to incident and remained current, indicated Resident R3 had behaviors of resistant with care. Review of an incident report dated 8/28/24, indicated that Resident R3 developed a 1.5 c.m. x 2.0 c.m. x 0.1 c.m. head laceration with a bruise requiring steri strips (tape that is used in place of sutures) to close when NA Employee E8 attempted to readjust a sheet around his waist to keep him from picking at his brief with no additional assistance when turning Resident R3 who cannot hold himself or stop himself from rolling, NA Employee E8 hit Resident R3s head off of the overbed table causing the laceration. During an interview on 9/25/24, at 8:15 a.m., NA Employee E5 stated that Resident R3 is rigid and required two staff since he becomes combative with care. NA Employee E5 stated that he frequently is assigned to Resident R3. The Nurse Aides use a care sheet (a sheet shown to the surveyor and is on each nursing unit as a quick reference for each residents care needs for the Nurse Aides to utilize) but they also get report between shifts in case there are any changes to determine the assistance required by the residents. During an interview on 9/25/24, at 8:40 with NA Employee E6 and E7 indicated that resident care is identified on the care sheets but they also get report between shifts in case there are any changes. During an interview on 9/26/24, at 10:22 a.m., the Director of Nursing confirmed that the facility failed to provide appropriate assistance to prevent falls and an injury, resulting in actual harm of a leg fracture for one of three residents reviewed (Resident R91) and a head laceration for one of three residents (R3). 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.20(a)(b) Staff development 28 Pa. Code 201.29(a)(c)(d) Resident rights

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F 0943 Level of Harm - Potential for minimal harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 39311 Based on review of facility documents and staff interview, it was determined that the facility failed to provide training on abuse, neglect, and exploitation prevention for two of ten staff members (Employee E3 and E4). Findings include: Review of the Facility Assessment most recently reviewed 7/12/24, included in the list of training topics, Abuse, Neglect, and Exploitation. Review of facility provided documents and training records revealed the following staff members did not have documented training on abuse, neglect, and exploitation prevention. Unit Clerk Employee E3 had a hire date of 4/16/07, failed to have abuse, neglect, and exploitation prevention in-service education between 4/16/23, and 4/16/24. Nurse Aide Employee E4 had a hire date of 5/19/14, failed to have abuse, neglect, and exploitation prevention in-service education between 5/19/23, and 5/19/24. During an interview on 9/26/24, at approximately 1:09 p.m. the Assistant Director of Nursing confirmed that the facility failed to provide training on abuse, neglect, and exploitation prevention for two of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.

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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 0944 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 39311 Based on review of facility documents and staff interview, it was determined that the facility failed to provide training on Quality Assurance and Performance Improvement (QAPI) for two of ten staff members (Employee E1 and E2). Findings include: Review of facility provided documents and training records revealed the following staff members did not have documented training on the QAPI Program. Nurse Aide (NA) Employee E1 had a hire date of 5/19/14, failed to have QAPI Program in-service education between 5/19/23, and 5/19/24. NA Employee E2 had a hire date of 7/1/02, failed to have QAPI Program in-service education between 7/1/23, and 7/1/24. During an interview on 9/26/24, at approximately 1:09 p.m. the Assistant Director of Nursing confirmed that the facility failed to provide training on the QAPI Program for two of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.