STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395640	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John J Kane Regional Center-MC	100 Ninth Street McKeesport, PA 15132

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** 39311 Based on review of facility policies and documents, clinical record review, and staff interview, it was determined that the facility failed to protect residents from neglect that resulted in the actual harm of a leg fracture and a skin tear that required sutures for one of three residents (Resident R1). Findings include: Review of the facility policy, Abuse - Resident and Reasonable Suspicion of a Crime dated 1/16/24, defined neglect as 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. Review of the clinical record indicated Resident R1 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 7/11/24, included diagnoses of morbid obesity (chronic disease in which a person has a body mass index (BMI) of 40 or higher or a BMI of 35 or higher and is experiencing obesity-related health conditions) and osteoarthritis (degeneration of the joint causing pain and stiffness). Review of Section G: indicated that Resident R1 required substantial/maximal assistance to roll left and right. Review of a physician order dated 10/18/23, indicated Resident R1 required an assist of three staff members for bed mobility. Review of Resident R1's plan of care for Morbid obesity - impaired mobility intervention dated 12/5/23, indicated to provide Assist of 3 for turning and repositioning. Review of Resident R1's plan of care for Risk for falls intervention dated 7/31/24, indicated to Provide individualized toileting interventions based on needs/patterns. (continued on next page)

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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a progress note dated 9/3/24, at 10:32 a.m. indicated, CNA (nurse aide) reports that while rolling patient to put her own the bedpan. Resident assisted with rolling by grabbing onto the headboard. Resident then stated she was starting to fall. CNA reports that resident fell face down hitting her legs first causing a laceration to her left lower leg and decrease in ROM (range of motion) to left knee as resident states it hurts to move. Was able to leave resident on the floor until EMS (emergency services) arrived. Pressure dressing applied to left lower leg, bleeding did stop prior to dressing being applied. During this time resident stated pain to right knee and she thinks her left knee is broke. MD (doctor of medicine) and son notified. Review of facility submitted information dated 9/4/24, indicated, On 9/3/2024 at approximately 10:05 AM alert x 3 resident [Resident R1] fell from the bed. During AM care resident assisted CNA (nurse aide) to roll by grabbing the headboard and rolling to the left side of bed. The CNA then reached for the bedpan and resident pulled to far causing body weight (338 pounds) to carry the resident over the side of the bed. CNA attempted to prevent resident from rolling too far but lower body exited the bed. Upper body was lowered to the floor by CNA. Resident assessed by RN (registered nurse). Laceration noted to left knee. Area cleansed with normal saline, and dressing applied. Resident complaint of right knee pain. MD notified and ordered out to hospital for evaluation. Review of emergency room documentation dated 9/3/24, at 3:30 p.m. indicated Resident R1 was treated for a 7 cm (centimeter) laceration that required 13 sutures and a comminuted fracture of the distal femur (a fracture of the lower end of the thigh bone, that resulted in the bone breaking into multiple pieces). Resident R1 was transferred to a higher-level hospital for additional evaluation. Review of an employee statement written by NA Employee E1 dated 9/3/24, indicated, Before proceeding to do care on [Resident R1] I asked the nurses how she is with transfer and bed mobility. The nurses at the nursing station said [Resident R1] would be fine with care and to get her up if she wants to. So then I proceeded to do my care. When I went in [Resident R1] room the plan was to wash her up and change her. Before washing she wanted to get on bed pan so I proceeded to put her on the bed pan. [Resident R1] grabs the left side of the headboard with her right hand to pull herself over. She did well with pulling herself over so I didn't have to struggle. She was turned on her left side positioned well before slowly starting to fall over the bed. When she fell she fell to her knees first then we were able to lay her down on her side slowly. Review of a facility document dated 9/9/24, stated, During an investigation of a resident incident on 9/3/24, it was determined that the staff member did not follow the plan of care / orders while caring for a resident. [NA Employee E1] failed to identify the bed mobility order prior to care. Resident requires 3 staff for bed mobility. [NA Employee E1] rolled the resident by herself, and resident fell out of the bed resulting in two fractures. [NA Employee E1] is placed on the do not return list for failure to follow physician orders and verify bed mobility prior to care. Review of a facility submitted Report Form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property dated 9/10/24, included the information, CNA failed to ensure resident orders or plan of care for bed mobility prior to performing care. Allegation of neglect substantiated. During an interview on 9/19/24, at approximately 2:00 p.m. the Director of Nursing confirmed the facility failed to protect residents from neglect that resulted in the actual harm of a leg fracture and a skin tear that required sutures for one of three residents (Resident R1). (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 0600 Level of Harm - Actual harm Residents Affected - Few	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 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** 39311 Based on review of facility policies and documents, clinical record review, and staff interview, it was determined that the facility failed to provide adequate supervision to prevent falls that resulted in the actual harm of a leg fracture and a skin tear that required sutures for one of three residents (Resident R1). Findings include: Review of the facility policy, General Guidelines dated 1/16/24, indicated All care and services must be delivered as prescribed by the practitioner, and according to thre resident's person-centered plan of care. Review of the American Congress of Rehabilitation Medicine - 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 R1 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 7/11/24, included diagnoses of morbid obesity (chronic disease in which a person has a body mass index (BMI) of 40 or higher or a BMI of 35 or higher and is experiencing obesity-related health conditions) and osteoarthritis (degeneration of the joint causing pain and stiffness). Review of Section G: indicated that Resident R1 required substantial/maximal assistance to roll left and right. Review of a physician order dated 10/18/23, indicated Resident R1 required an assist of three staff members for bed mobility. Review of Resident R1's plan of care for Morbid obesity - impaired mobility intervention dated 12/5/23, indicated to provide Assist of 3 for turning and repositioning. Review of Resident R1's plan of care for Risk for falls intervention dated 7/31/24, indicated to Provide individualized toileting interventions based on needs/patterns. Review of a progress note dated 9/3/24, at 10:32 a.m. indicated, CNA (nurse aide) reports that while rolling patient to put her own the bedpan. Resident assisted with rolling by grabbing onto the headboard. Resident then stated she was starting to fall. CNA reports that resident fell face down hitting her legs first causing a laceration to her left lower leg and decrease in ROM (range of motion) to left knee as resident states it hurts to move. Was able to leave resident on the floor until EMS (emergency services) arrived. Pressure dressing applied to left lower leg, bleeding did stop prior to dressing being applied. During this time resident stated pain to right knee and she thinks her left knee is broke. MD (doctor of medicine) and son notified. (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 facility submitted information dated 9/4/24, indicated, On 9/3/2024 at approximately 10:05 AM alert x 3 resident [Resident R1] fell from the bed. During AM care resident assisted CNA (nurse aide) to roll by grabbing the headboard and rolling to the left side of bed. The CNA then reached for the bedpan and resident pulled to far causing body weight (338 pounds) to carry the resident over the side of the bed. CNA attempted to prevent resident from rolling too far but lower body exited the bed. Upper body was lowered to the floor by CNA. Resident assessed by RN (registered nurse). Laceration noted to left knee. Area cleansed with normal saline, and dressing applied. Resident complaint of right knee pain. MD notified and ordered out to hospital for evaluation. Review of emergency room documentation dated 9/3/24, at 3:30 p.m. indicated Resident R1 was treated for a 7 cm (centimeter) laceration that required 13 sutures and a comminuted fracture of the distal femur (a fracture of the lower end of the thigh bone, that resulted in the bone breaking into multiple pieces). Resident R1 was transferred to a higher-level hospital for additional evaluation. Review of an employee statement written by NA Employee E1 dated 9/3/24, indicated, Before proceeding to do care on [Resident R1] I asked the nurses how she is with transfer and bed mobility. The nurses at the nursing station said [Resident R1] would be fine with care and to get her up if she wants to. So then I proceeded to do my care. When I went in [Resident R1] room the plan was to wash her up and change her. Before washing she wanted to get on bed pan so I proceeded to put her on the bed pan. [Resident R1] grabs the left side of the headboard with her right hand to pull herself over. She did well with pulling herself over so I didn't have to struggle. She was turned on her left side positioned well before slowly starting to fall over the bed. When she fell she fell to her knees first then we were able to lay her down on her side slowly. Review of a facility document dated 9/9/24, stated, During an investigation of a resident incident on 9/3/24, it was determined that the staff member did not follow the plan of care / orders while caring for a resident. [NA Employee E1] failed to identify the bed mobility order prior to care. Resident requires 3 staff for bed mobility. [NA Employee E1] rolled the resident by herself, and resident fell out of the bed resulting in two fractures. [NA Employee E1] is placed on the do not return list for failure to follow physician orders and verify bed mobility prior to care. Review of a facility submitted Report Form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property dated 9/10/24, included the information, CNA failed to ensure resident orders or plan of care for bed mobility prior to performing care. Allegation of neglect substantiated. During an interview on 9/19/24, at approximately 2:00 p.m. the Director of Nursing confirmed the facility failed to provide adequate supervision to prevent falls that resulted in the actual harm of a leg fracture and a skin tear that required sutures for one of three residents (Resident R1). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(e)(1) Management. 28 Pa. Code 201.20(b)(1) Staff Development. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10(c)(d) Resident care policies. (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	28 Pa Code 211.12(d)(1)(2)(5) 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on review of facility policy, clinical records, and staff interviews it was determined that the facility failed to implement pharmaceutical services to ensure accurate provision of medications for one of four residents (Residents R2). Findings include: Review of the facility policy, General Pharmacy Standards dated 1/16/24, indicated the contracted pharmacy will include Accurately dispensing prescriptions based on authorized prescriber orders. Review of Residents R2's admission record indicated she was admitted to the facility on [DATE]. Review of Residents R2's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 8/7/24, indicated that she had diagnoses that included dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and aftercare following surgery. Review of Residents R2's care plan for pain dated 8/4/24, indicated to medicate as ordered. Review of a psychiatric evaluation dated 8/8/24, indicated a new order for gabapentin (medication used to treat seizures, nerve pain, and an off-label use for depression) 100 mg (milligrams) twice per day. Review of a progress note dated 8/9/24, at 8:15 a.m. indicated a new order for gabapentin 100 mg twice daily for anxiety. Review of Residents R2's medication administration record (MAR) for September 2024, indicated: -8/09/24, morning, gabapentin 100 mg provided. -8/09/24, afternoon, gabapentin 800 mg provided. -8/10/24, morning, gabapentin 800 mg provided. -8/10/24, afternoon, gabapentin 800 mg provided. -8/11/24, morning, gabapentin 800 mg provided. -8/11/24, afternoon, gabapentin 800 mg provided. -8/12/24, morning, gabapentin 800 mg provided. -8/12/24, afternoon, gabapentin 800 mg refused. -8/13/24, morning, gabapentin 800 mg provided. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8/13/24, afternoon, gabapentin 800 mg refused by family. -8/14/24, morning, gabapentin 800 mg provided. During an interview on 9/19/24, at approximately 2:00 p.m. Director of Nursing confirmed that there was a pharmacy error, and the gabapentin 100 mg, twice daily order was inadvertently changed to a gabapentin 800 mg, twice daily, and further confirmed that Resident R2 received the incorrect dose from 8/9/24, through 8/14/24. During an interview on 8/7/24, at 11:42 a.m. the Director of Nursing (DON) confirmed that the facility failed to implement pharmaceutical services to ensure accurate provision of medications for one of four residents. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.9 (a)(1)(k)(l)(1)(2)(3)(4) Pharmacy services 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(1)(5) Nursing services.