

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395640	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2024
NAME OF PROVIDER OR SUPPLIER John J Kane Regional Center-MC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311</p> <p>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 four residents (Resident R1). This was identified as past non-compliance.</p> <p>Findings include:</p> <p>Review of the facility policy Wanderguard and Elopement Prevention dated 1/6/24, most recently reviewed 11/6/24, indicated it is the policy of the facility to implement safety measures for residents who wander and/or are at risk for elopement to attempt to prevent elopement.</p> <p>Review of the clinical record revealed Resident R1 was originally admitted to the facility on [DATE], at 6:14 p. m. with diagnoses of high blood pressure and alcohol abuse disorder.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility submitted information dated 12/7/24, indicated. On 12/7/24, at approximately 5:30 AM during resident accountability checks it was determined that resident [Resident R1] was not in his room. Supervisors and security notified, and facility check was done. CCTV (closed-circuit television) camera reviewed, resident observed leaving 3A unit at 10:00 p.m. on 12/6/24 ambulating independently, fully dressed in pants, hat, winter coat, and surgical mask. Resident viewed on CCTV entering the main lobby. Resident asked security how to exit the building. Resident stated, How do I get out of here? Security guard did ask will you be returning [Resident R1] stated I ' m finished for the day and leaving. Security had no idea [Resident R1] was a newly admitted resident to the facility and was under the impression he was a visitor. [Resident R1] exited the facility at 10:04 p.m. Resident ' s sister notified. Sister stated he might be at a friend ' s house located near the facility. Sister provided staff with a name, address, [Resident R1 ' s] cell phone number. Police notified and given all information provided by sister. [Local] police reported resident was not found at address provided and no answer to resident ' s cell phone. Sister was updated. UPDATE: Several attempts were made to contact [Resident R1]. A message was left on his personal cell phone requesting a call back. At 9:26 p.m. on 12/8/24, [Resident R1] returned a call to the center stating he would like to enter a program and requested a call back. Call was returned and message left for [Resident R1] to call the DON (Director of Nursing) on per person cell phone or to the facility. On 12/9/24 at 11:00 a.m., Police reported that [Resident R1 ' s] cell phone was pinged at his home. At 11:15 a.m. Police arrived at his home and spoke with [Resident R1]. Police reported that he was alert and orient X3 (alert to person, place, and time), clean, neat, and the home was in good order. [Resident R1] stated to the officers that he was at [facility] for a few hours, but they did not have the program he wanted so he left the facility. [Resident R1] called a jitney (vehicle carrying passengers for a low fare) for transportation. At 11:25 a.m. police called and stated that the paramedics visited and evaluated [Resident R1]. Assessment was that he is alert and oriented and refused to go to the hospital for evaluation and did not want to return to the facility.</p> <p>Review of a Safety Check Record dated 12/7/24, indicated for a newly admitted resident, with no name indicated, that the resident was coded as B (Safe in Bed) at 12:00 a.m., 1:00 a.m., 2:00 a.m., 3:00 a.m., 4:00 a.m., 5:00 a.m., 6:00 a.m., and 7:00 a.m. Each of these entries was initialed with the initials of Registered Nurse (RN) Employee E2, and each of the entries was had circular marks written over the initials, partly obscuring them. The initials remained legible.</p> <p>Review of an employee statement written by Nurse Aide (NA) Employee E1 on 12/7/24, at 5:30 a.m. indicated, I came on shift around 10:45. Aides on unit + nurse gave me report saying the resident was new admit and that he was continent and selfcare and that he stayed in his room. I notices his door was shut so I did not go into his room to physically check on him. I signed off accountability on their word. I also charted before completing care because it is a very busy unit and I don ' t always have the time at the end of shift to complete it. So I charted what report I was given and was going to complete the rest after my morning rounds. The nurse made it down to the room before I got there to do his vitals and noticed he was not in his room. We then proceeded to check the entire unit for resident ' s whereabouts. When we could not locate him, we made supervisors aware.</p> <p>Review of facility provided human resource documents indicated NA Employee E1 failed to do accountability and safety checks every two hours on a newly admitted resident and further documented ADL (activities of daily living) care in the electronic medical record.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/23/24, at approximately 2:00 p.m. the Director of Nursing confirmed that the facility failed to provide adequate supervision to prevent elopement for one of four residents.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(e)(1) Management.</p> <p>28 Pa. Code 201.20(b)(1) Staff Development.</p> <p>28 Pa. Code 201.29(a) Resident rights.</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies.</p> <p>28 Pa. Code 211.11(d) Resident care plan.</p> <p>28 Pa Code 211.12(d)(1)(2)(5) Nursing services.</p>		