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	04/30/2026

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.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 review of facility policy, 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 that created an immediate jeopardy situation for one of forty residents (Resident R1).Findings include: Review of the facility policy, Elopement: Missing Resident dated, 6/30/25, indicated It is the policy of the facility to provide each resident with adequate monitoring and interventions to maintain safety. If a resident is discovered to be missing, the center will immediately take all possible measures to assure the resident's safe return. 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 care needs) dated 3/11/26, included diagnoses of encephalopathy (broad term for any brain disease, damage, or dysfunction that alters mental state, causing confusion, memory loss, and personality changes) and coronary artery disease (damage or disease in the heart's major blood vessels). Review of the facility diagnosis list included dementia (a group of symptoms that affects memory, thinking and interferes with daily life), dysphagia, muscle weakness, unsteadiness on feet, history of falling, adult failure to thrive. Review of hospital documentation provided to the facility upon admission on [DATE], indicated, She presents emergency department after being found by her daughter covered in feces, urine, and vomit. Per EMS (emergency medical services) that house was in a poor state of hygiene when they picked patient up ED (emergency department) reported concerns that Adult Protective Services may need to be called to help provide resources. The patient's daughter lives near and checks on her daily, when I saw the patient the daughter stated that she felt like her last normal day was 48hrs ago, the last two days she said she saw her sitting on the same couch in her house but did not realize she was developing pressure sore, then yesterday realized that she had soiled herself and called EMS. The daughter is also not the best historian overall and it's difficult to get an accurate assessment. Per EMS report to ED, they were concerned about the condition of the patient's home, found her covered in urine, feces, and vomit, wearing multiple shirts and with her house key safety pinned to her shirt. Daughter lives next door and visit's patient regularly to help with care and she is the one that found her. Review of an Elopement Evaluation assessment completed on 5/19/25, indicated Resident R1 was not at risk for elopement due to not being able to ambulate or use a wheelchair independently. Review of Elopement Evaluation assessments completed on 7/2/25, and 9/18/25, indicated Resident R1 was not at risk for elopement due to not having exit-seeking behaviors. Further review of the clinical record failed to reveal additional elopement assessments after 9/18/25. Review of Resident R1's plan of care initiated 5/19/25, did not include goals and interventions related to elopement. Review of Resident R1's plan of care for Discharge Planning initiated 5/19/25, indicated the risk for long-term care, unable to care for self, limited assistance in the community. Possible protective care services. The care plan included the goal of, Resident will be discharged appropriately/ or will remain long term care. Review of a physician's order dated 5/19/25, reordered 3/22/26, indicated, Resident level of supervision: May move about unit and facility without supervision but may not leave facility without supervision. (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a physician's order dated 4/2/26, indicated, Overnight LOA (leave of absence) 4/2 to 4/3 with meds. Review of a physician note dated 3/6/26, at 5:32 a.m. indicated that on 3/5/26, Resident R1 stated she is ready to go home. The plan listed in the physician notes was, For PT (physical therapy), OT (occupational therapy) and social worker to determine safety at home and follow-up with PCP (primary care physician). We will discharge when above is in place. Review of a progress note dated 3/20/26, at 1:02 p.m. indicated resident was heard to state, If I get to go home with my dtr (daughter), I'm not coming back. Review of a progress note dated 3/31/26, at 2:23 p.m. indicated LOA from 4/2-4/3, MD notified and agreeable, med list sent to pharmacy. Review of a late entry progress note dated 4/1/26, at 1:30 p.m. (created 4/7/26), indicated, Resident, nursing, SS (Social Services), and therapy attended meeting to discuss resident request of possible discharge in the future. Resident was admitted in 2025 as an APS (Adult Protective Services) case due to not being able to care for herself at home. Resident has been working in therapy with hopes to discharge, but does not have a safe place to go at this time. In therapy, resident still needed some assistance and cueing with ADLs (activities of daily living). Before meeting began, resident got her wheelchair stuck and needed help. SS explained to resident that if she would be home alone, she would have to be able to do these things by herself. Resident had a planned LOA Thursday with an overnight stay until Friday and return around 5pm. When resident was asked where she was going, she could not give SS a detailed answer. She stated a church event. [Physical Theryapy Employee E1] asked resident multiple times how she would be getting to the event, and resident kept repeating my daughter will pick me up. However, her daughter does not drive. Resident stated she would like to get an apartment that is handicap accessible and have her daughter be a paid caregiver. None of these things are in place at this time. This meeting was to touch base with resident on her wishes of some day discharging if possible. Review of a progress note dated 4/4/26, at 12:12 a.m. indicated, This resident was supposed to be back from her LOA at by 6pm No answer and message left for daughter (name and contact phone number) regarding the LOA of this resident. Review of a progress note dated 4/4/26, at 1:11 a.m. indicated, On the LOA paper this resident signed herself out leaving [phone number]; in calling this number the automated voice comes on saying the call cannot be completed as dialed and to please check the number or ask the operator. Review of a progress note dated 4/4/26, at 1:16 a.m. indicated, Attempted to call the daughter again [phone number] this time straight to voicemail. Review of a progress note dated 4/4/26, at 2:42 a.m. indicated, Attempted to call [daughter] regarding the LOA and where abouts of her mother. Again, the LOA was for 4/2/26 until 4/3/26 at 6PM message left for the daughter [phone number] to call us back. Review of a progress note dated 4/6/26, at 11:05 a.m. indicated, Call placed to [daughter / phone number] and message left to call facility. Call placed to [pastor] of resident's church at [phone number] and number restricted. Call placed to [resident's church friend] at [phone number] and straight to busy signal. Review of a progress note dated 4/7/26, at 9:54 a.m. indicated that the facility attempted to contact the resident's primary care physician in the community but was unable to do so. A message was received that indicated the office was closed since 2/1/26. Review of a progress note dated 4/9/26, at 11:11 a.m. indicated, Spoke with APS agent with update. This nurse received information from the business office. The progress note included an email address, physical address, and phone number for Resident R1's daughter. Review of a progress note dated 4/28/26, at 12:25 p.m. indicated that APS was contacted, who confirmed that they were able to make contact with Resident R1's daughter, who stated that the resident was fine. Resident R1's daughter was unwilling to provide further information or the location of Resident R1. During an interview on 4/28/26, at approximately 12:35 p.m. the Director of Nursing and the Assistant Director of Nursing confirmed that the facility failed to take actions other than phone calls when Resident R1 did not return to the facility as scheduled on 4/3/26, that they were unaware of the location of Resident R1, and had not known of her location or safety since she departed on 4/2/26. Review of information submitted by the facility dated 4/6/26, indicated that on 4/4/26 [incorrect date, incident occurred on 4/3/26], at approximately 6 PM alert x 3 (mentally alert (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to person, place, and time) [Resident R1] (BIMS 15, indicating cognitively intact) did not return from an overnight leave of absence. Resident is alert, verbal and able to make needs known. Resident went on an approved LOA from 4/3/26 to 4/4/26 [correct dates are 4/2/26 to 4/3/26] with her daughter to daughter's home. Resident was picked up by her daughter, who is her emergency contact and a friend via private car. When resident did not return to facility at 6 PM on 4/4/26 [correct date 4/3/26] multiple attempts were made to call all listed contacts. Daughter called and message left with no response. Resident's second and third contacts called and unavailable. MD (Doctor of Medicine) notified, and facility continued to make multiple attempts to contact resident. When MD updated of residents non return to facility resident considered AMA (against medical advice). Adult protective services notified and informed that resident left on a therapeutic LOA with one day of meds, all belongings and wheelchair to daughter's home. Resident able to ambulate with assistance and was in process of completing care giver training with daughter for possible discharge. APS to investigate further. Facility called 911 for a wellness check. [Local] Police Department returned call stating no answer at residence but utilities appear to be on. The NHA and the DON were made aware that an Immediate Jeopardy situation existed and a corrective action plan was requested. The Immediate Jeopardy template was provided to the facility administration at this time. The Immediate Jeopardy began on 4/2/26. On 4/28/26, at 6:05 p.m. an acceptable Corrective Action Plan was reviewed which included the following interventions: Actions Related to Resident R1:4/3/26: Resident failed to return from approved LOA at 6:00 p.m. Calls made to daughter at 11:45 PM, 11:49 PM (no answer).4/4/26: Documentation of phone calls from 12:12 a.m. through 2:42 a.m. (2.5 hours) to attempt to locate resident through daughter and phone number listed on LOA form.4/6/26: Adult Protective Services at 11:20AM. Notification to local police at 5:20 PM (three days after Resident did not return). Calls made by staff at 11:04 AM, 12:35 PM, 12:44PM to daughter number. Calls made to Pastor (second contact person) at 11:08AM, 11:09AM, 12:34PM, 12:45PM and 12:50PM. Calls made to Friend (third contact) at 11:10AM, 12:34 PM.4/7/26: Attempt made to contact residents PCP in community. Number called and office closed as of 2/1/26. Ombudsman notified. Attempted to call pastor.4/9/26: Spoke with APS agent with update of daughter's contact information received from the business office. Identification of other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. Immediately the facility will reevaluate all residents to ensure any wandering behaviors are identified; update care plans as needed and ensure adequate.Elopement risk assessment will be completed on every resident currently in facility completed by 4/28/26. Thereafter Elopement Risk Assessment will be done on admission, annually, and quarterly MDS review, and with any change in condition.Resident care plans will be updated to include elopement risk, residents identified as an elopement risk will have a Wander guard placed and security notified immediately completed by 4/28/26.Accountability check sheets used to account for residents' location at the beginning and end of each shift will be completed daily to ensure monitoring of residents by 4/28/26.Residents exhibiting wandering/elopement behavior will be identified on 24hr report for follow up and safety by 4/28/26.Residents that exhibit wandering/elopement behavior will be placed on q1h (every hour) safety checks x 72 hours by 4/28/26.Resident contact information will be verified before each Therapeutic Leave of Absence to ensure viable phone number and address. Measures to be put into place or what system changes will you make to ensure that the deficient practice does not occur? Facility will in-service all scheduled nursing staff, including agency, beginning immediately on Elopement-Missing Resident and Therapeutic Leave of Absence policy on 4/28/26, with completion on 4/29/26, at 1:00 p.m. Staff will be identified via facility roster/signature log to ensure full attendance.Comprehensive care planning, addressing elopement risk and level of supervision.Comprehensive whole house elopement observations have been completed.Therapeutic Leave of Absence policy created 4/28/26.Elopement policy reviewed immediately at QA/QAPI (Quality Assurance and Process Improvement) on 4/28/26. How will the corrective action be monitored to ensure that the deficient practice will not recur, i.e. what quality assurance programs (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	will be established? ADON/designee will perform monitoring of Leave of Absence log to ensure the safe and timely return of residents for completion three per week for four weeks, beginning on 4/28/26; weekly for four weeks; biweekly for four weeks; then monthly for four months. Review of resident clinical records on 4/29/26, confirmed that all residents were reevaluated for elopement risk on 4/28/26. Review of facility-provided sign-in sheets, dated 4/28/26, and 4/29/26, confirmed reeducation was provided to licensed nurses on the updated Elopement / Missing Resident policy and the Therapeutic Leave of Absence policy. During interviews conducted on 4/29/26, confirmed 15 of 15 nurses (facility-employed and agency staff) received reeducation on the updated Elopement / Missing Resident policy and the Therapeutic Leave of Absence policy. After confirming the plan was implemented as outlined the Immediate Jeopardy was lifted. During an interview on 4/29/26, at approximately 12:00 p.m. the Chief Nursing Officer confirmed that the facility failed to provide adequate supervision to prevent elopement that created an immediate jeopardy situation for one of forty residents. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(e)(1) Management.28 Pa. Code 201.29(a) Resident rights.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa Code 211.12(d)(1)(2)(5) Nursing services.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job descriptions, facility documents, clinical records, and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility to provide adequate supervision to prevent elopement that created an immediate jeopardy situation for one of forty residents (Resident R1).Findings include: Review of the facility-provided Nursing Home Administrator (NHA) job description indicated the NHA directs the day-to-day functions of the facility and manages all aspects of the Center's operations to ensure the safety and comfort of the residents is maintained, and the monitoring of service providers. Work is performed in accordance with federal, state, and local standards, guidelines, and regulations that govern long-term facilities to assure that high quality care is provided to all residents. Review of the facility-provided Director of Nursing (DON) job description indicated the DON's responsibilities are to plan, organize, develop, and direct the overall operation of the Nursing Department in accordance with Professional Nursing Law, and current federal, state, and local standards, guidelines, and regulations that govern the facility. Based on findings identified in this report, the facility failed to take appropriate action when a resident failed to return to the facility after a leave of absence. The previously employed NHA and the previously employed DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 4/30/26, at approximately 12:30 p.m. the current NHA and current DON confirmed that facility administration failed to effectively manage the facility to provide adequate supervision to prevent elopement that created an immediate jeopardy situation for one of forty residents 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.