STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395643	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John J Kane Regional Center-GI	955 Rivermont Drive Pittsburgh, PA 15207

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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:	(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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, documents, clinical record and staff interviews, it was determined that the facility failed to make certain a resident was free from the use of physical restraints without a physical restraint order for one of eight residents reviewed. (Resident R2).Findings include:Review of facility policy, Abuse-Resident and Reasonable Suspicion of a Crime reviewed 1/7/25, indicated the resident is to be treated with consideration, respect and full recognition of his/her dignity and individuality. This policy is part of the centers overall prevention of abuse, neglect, exploitation of residents, and misappropriation of resident property program.Review of facility policy, Resident Rights and Responsibilities reviewed 1/7/25, indicated the facility is to treat each resident with dignity and respect. All activities and interactions to assist the resident in maintaining and enhancing self-esteem and self-worth by incorporating resident goals, preferences, and choices.Review of facility policy, Restraints-Physical reviewed 1/7/25, indicated the facility is to ensure residents are free from physical restraints for purposes of discipline or convenience unless they are required to treat a medical symptom AND are the least restrictive alternative for the least amount of time with ongoing evaluation of need.Review of the Resident Assessment Instrument User's Manual Effective October 2024 indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aids in detecting cognitive impairment. The BIMS score suggests the following distributions:-13-15: cognitively intact-8-12: moderately impaired-0-7: severe impairmentReview of the clinical record indicated Resident R2 was admitted to the facility on [DATE].Review of the Minimum Data Set (MDS-federally mandated assessment of a resident's abilities and care needs) dated 10/28/25, included diagnoses of vascular dementia (decline in thinking, memory, and behavior caused by reduced or blocked blood flow in the brain), peripheral vascular disease (circulation disorder where blood vessels outside the heart become narrowed, blocked, or weakened), anxiety disorder (group of mental health conditions characterized by persistent and excessive feelings of worry, fear, or panic that can significantly impact daily life). Review of Section C: Cognitive Patterns, Question C0500: BIMS Summary Score revealed Resident R2's score to be 0.Review of Resident R2's orders revealed no order for bed to be against wall and no restraints of any kind every ordered.Review of incident report of 11/11/25, revealed resident was found at 12 p.m. by therapy staff in bed with bed pushed against wall, over bed table over resident, two chairs, one wheelchair and one nightstand all barricaded him in the bed.Review of interview with staff member on 11/11/25, revealed that she was trying to keep resident safe. Resident had placed himself on floor multiple times that day, was combative with care, as well as verbally aggressive. Resident was not harmed and showed no signs of distress; resident remained on locked behavioral dementia unit.Review of progress notes revealed social services met with the resident on 11/11/25 for psychosocial well-being with no issues identified.During an interview with the Director of Nursing and Nursing Home Administrator on 11/25/25, at approximately 1:00 p.m. it was confirmed that the facility failed to make certain a resident was free from the use of physical restraints without a physician's order for one of eight residents reviewed.28 Pa. Code 201.18 (e)(1) Management.28 Pa. Code 201.29 (a)(c)(d) Resident Rights.28 Pa. Code 211.12 (d)(5) Nursing Services.28 Pa. Code 211.8 (d)(e)(f) Use of Restraints.

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	395643	A. Building B. Wing	11/25/2025

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John J Kane Regional Center-GI	955 Rivermont Drive Pittsburgh, PA 15207

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and documents, clinical record review, and staff interviews, it was determined that the facility failed to provide adequate supervision to prevent falls that resulted in a laceration (deep cut) for one of eight residents (Resident R1).Findings include:Review of the facility policy, Abuse-Resident and Reasonable Suspicion of a Crime reviewed 1/7/25, indicated the facility is to treat every resident with consideration, respect and full recognition of his/her dignity and individuality. This policy is part of the centers overall prevention of abuse, neglect, exploitation of residents, and misappropriation of resident property program. Neglect is 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. Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person.Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2024, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:-13-15: cognitively intact-8-12: moderately impaired-0-7: Severe impairmentReview of the clinical record indicated Resident R1 was admitted to the facility on [DATE].Review of the Minimum Data Set (MDS- periodic assessment of resident care needs) dated 10/26/25, included diagnoses of diabetes (high blood glucose (sugar) levels), cardiomyopathy (disease of the heart muscle which makes it hard for the heart to pump blood), congestive heart failure (chronic condition where the heart can't pump enough oxygenated blood to meet the body's needs), morbid obesity (extremely overweight). Review of Section C: Cognitive Patterns, Question C0500 BIMS Summary Score revealed Resident R1's score to be 0.Review of the MDS dated [DATE], Section GG: Functional Abilities indicated Resident R1had no impairment of upper or lower extremities, is partial to moderate assistance with rolling from lying on back to left or right and return to back when lying on the bed.Review of a progress note dated 11/2/25, at 1:58 a.m. Documents sent with resident to the hospital.Review of a progress note dated 11/2/25, at 2:07 a.m. Called report to [NAME] hospital, doctor took report of wound on resident's leg was a large open wound down to the tendon. Pressure applied till bleeding stopped then pressure dressing applied. Patient sent to [NAME] hospital.Review of progress notes dated 11/2/25, at 5:46 a.m. facility spoke with nurse at [NAME] hospital ER stated an x-ray was done on the right leg. No breaks that they are numbing the area and are going to stitch up, and he should be headed back our way shortly.Review of progress notes dated 11/2/25, at 6:30 a.m. nurse called from [NAME] ER stated, they stitched him up and would be sending hm back on Keflex. Supervisor notified.Review of a progress note dated 11/2/25, at 8:02 a.m. indicated Resident R1 was being changed by CNA, started to cough and rolled out of bed receiving a laceration to the right lower leg.Resident R1's orders on 10/22/25 are for bed mobility assist of 1, on 11/3/25, resident orders changed to bed mobility assist of 2.Resident's R1 plan of care for Falls on 10/27/25, monitor resident's position in bed every two hours. On 11/3/25, plan of care updated to assist of 2 with bed mobility and Hoyer lift due to declining functional ability. Ensure fall mats are down when in bed.Review of the facility incident report dated 11/3/25, indicated, Resident rolled out of bed at 0030, 11/2/25, during care. Was being changed by CNA when he started to cough and rolled out of bed. Assessed by RN. Sustained laceration to right calf, after hitting it off incremental unit. Resident care planned for 1 assist. Resident on bariatric air mattress. Care provided. MD notified. Order to transfer to ED for evaluation. Family notified. Abuse training was conducted with all staff completing training 11/4/25 through 11/6/25.During an interview on 11/25/25, at approximately 1:00 p.m. the Nursing Home Administrator and Director of Nursing confirmed the facility failed to provide adequate supervision to prevent falls that resulted in a laceration that required sutures in one of eight residents (Resident R1).28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(e)(1) Management.28 Pa. Code 201.29(a) Resident Rights.28 Pa. Code 211.10(C)(d) Resident Care policies.28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.