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	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John J Kane Regional Center-Gl	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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of professional standards of practice, facility policy, clinical record review and staff interview, it was determined that the facility failed to develop and implement care and services consistent with professional standards of practice to prevent the new development of pressure ulcers that resulted in hospitalization for the treatment of wounds. This resulted in actual harm for two of three residents with facility-acquired pressure ulcers. (Resident R15 and Resident R2).Findings include: Review of the US Department of Health and Human Services, Agency for Healthcare Research &; Quality, the Pressure Ulcer Best Practice Bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, standardized pressure ulcer risk assessment, and care planning and implementation to address the areas of risk. Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e., support surfaces, repositioning, and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement, and wound cleansing; using adjunctive therapies; and considering possible surgical repair. Review of the facility policy Wound Care - Pressure Ulcer / Injury Prevention, dated 1/22/26, indicated it is the facility's policy to ensure resident's receive care to prevent pressure ulcers/injuries, residents do not develop pressure ulcers unless the clinical condition demonstrates that they were avoidable, and residents with pressure ulcers receive necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from developing. Review of the clinical record indicated Resident R15 was admitted to the facility on [DATE]. Review of Resident R15's Minimum Data Set (MDS -periodic assessment of resident care needs) dated 4/7/26, included diagnoses of Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking) and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of Section GG: Functional Abilities indicated Resident R15 required Substantial assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) to roll left and right, to move from a sitting to a lying position, to transfer between a chair and the bed, and indicated that Resident R15 was Dependent (Helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of two or more helpers is required for the resident to complete the activity) on staff from moving from a lying position to a sitting position and moving from a sitting position to a standing position. Review of Section M: Skin Conditions, indicated Resident R15 did not have any pressure injuries at the time of the assessment. Review of Resident R15's Functional Abilities Assessment dated 4/6/26, indicated that Resident R15 required assistance to roll left and right and to move from a sitting to a lying position. The remainder of the mobility portion of the assessment was documented as, Not attempted due to medical condition or safety concerns. Review of Resident R15's Pressure Sore Risk assessment dated [DATE], indicated that Resident R15's ability to change and control body position was slightly limited. This is contradictory to the Functional Abilities Assessment also completed on 4/6/26. Review of Resident R15's admission Observation dated 4/6/26, indicated that Resident R15 had no skin alterations upon admission. (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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the plan of care dated 4/6/26, for Potential for Alteration in Skin Integrity indicated that staff should assist with weight position changes throughout the day and night. Review of a physician order dated 4/6/26, indicated that Resident R15 should have a Braden Observation weekly, for four weeks. Review of Resident R15's clinical record revealed no documentation for a Braden Observation on 4/13/26, and 4/20/26. Review of a physician order dated 4/6/26, indicated that Resident R15 should have a skin assessment completed on shower days, and for staff to chart any abnormalities in GPN (general progress notes). Document any abnormalities including skin integrity, circulation, and repositioning ability. Review of physician orders dated 4/6/26, indicated that Resident R15 required two-person assist for bed mobility, dressing, grooming, bathing, toileting, and transferring. Review of Resident R15's point of care history indicated that from 4/6/26, through 4/26/26, Resident R15 was assisted to change position eight times, by Nurse Aide Employee E1. No other documentation was present to indicate that other staff assisted in repositioning for Resident R15. Review of Resident R15's bathing record revealed that bathing was documented on 4/24/26, at 1:15 a.m. and at 10:35 p.m. Review of Resident R15's Medication Administration Record for April 2026, indicated that the ordered weekly skin assessment with shower was completed on Friday, 4/24/26, by Licensed Practical Nurse (LPN) Employee E2. Review of progress notes failed to reveal documentation that a skin alteration was identified. Review of facility staffing information revealed that LPN Employee E2 care for Resident R15 on day shift from 6:56 a.m. through 3:35 p.m., and was not present on either bathing time documented on 4/24/26. Review of a progress note dated 4/26/26, at 10:14 a.m. indicated, CNA (nurse aide) reports open area on resident's coccyx area is reddened and size of a fist, slight odor noted to wound, wound needs assessed by wound nurse for treatment orders, RN (registered nurse) to assess. Review of a Observation Detail List Report dated 4/26/26, at 11:44 a.m. indicated Coccyx breakdown, area measured at 10cm across 9 1/2 cm across, unopened area cleansed with soap and water, barrier cream applied and covered with optifoam (silicone foam) dressing. Review of a progress note dated 4/27/26, at 9:24 a.m. indicated that, MD (doctor of medicine) and EC (emergency contact) notified of area on coccyx, will update with treatment ordered by wound nurse. Review of a nurse practitioner's order dated 4/28/26, indicated, Cleanse with wound cleanser, pad dry, apply large foam dressing. Change daily. Review of wound nurse practitioner's note dated 4/29/26, at 5:29 p.m. indicated Resident R15 had new onset wounds discovered during care on 4/25/26. The assessment indicated: Wound #1 Sacral is an acute Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer acquired on 4/25/26, and has received a status of Not Healed. Initial wound encounter measurements are 8 cm length x 8.7 cm width x 0.1 cm depth. There was no drainage noted. Wound bed has 91-100% eschar (thick, dry layer of dead, necrotic tissue that forms over severe skin injuries). Wound #2 Left Heel is an acute Deep Tissue Pressure Injury Persistent non-blanchable deep red, maroon or purple discoloration Pressure Ulcer acquired on 4/29/26, and has received a status of Not Healed. Initial wound encounter measurements are 5.6 cm length x 5.6 cm width with no measurable depth. There was no drainage noted. Wound bed has 91-100% epithelialization (the process of repairing surface defects in skin and tissue damage). Review of a progress note dated 5/3/26, at 4:20 a.m. indicated that Resident R15 was sent to the emergency room. Further review of Resident R15's progress notes failed to reveal any further assessments of Resident R15's condition after the wound nurse practitioner report documented on 4/29/26. Review of a progress note dated 5/4/26, at 2:51 p.m. indicated that the hospital provided information that Resident R15 was about to get surg (surgery) and wound debridement. Review of a hospital note dated 5/3/26, at 8:43 a.m. indicated, Called next of kin. [Family member] was not aware pt (patient) was at the hospital. Gave update and informed [family member] pt will be admitted to ICU (Intensive Care Unit). Review of the hospital history and physical dated 5/3/26, indicated: Over the last 3-4 days SNF (skilled nursing facility) staff noted progressive altered mental status. EMS found him hypotensive (low blood pressure) and warm to touch and transported him to the ED (emergency department). There is high concern for malnutrition and dehydration and possible inadequate care at (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	the SNF, as described by family and suggested by clinical course. General surgery performed bedside debridement of a sacral wound Currently minimally responsive to verbal stimuli (only yes/no). [family member] confirms this is a new change from baseline 2 weeks ago. Review of a hospital note dated 5/4/26, at 3:08 p.m. indicated, Spoke with RN (registered nurse) at [facility] about patient wounds, RN stated patient was admitted to them with wounds noted in initial admission assessment. This note is contradictory to what was documented upon admission to the facility. Review of a hospital note dated 5/6/26, at 6:43 p.m. indicated that Resident R15 was treated for multiorgan dysfunction, septic shock, and soft tissue infection. Received a Sharp debridement (removal of dead tissue, slough (soft, moist, dead tissue that accumulates in a wound bed), or eschar using a scalpel or scissors) of sacral decubitus ulcer (pressure ulcer at the base of the backbone). Measurements 9cm x 9cm x 3.5 cm. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS dated [DATE], included diagnoses of Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior) and hypertension (high blood pressure). Review of Section GG: Functional Abilities indicated Resident R2 was Dependent on staff to roll left and right, to move from a sitting to a lying position, to move from a lying position to a sitting position, moving from a sitting position to a standing position, and to transfer between a chair and the bed. Review of Section M: Skin Conditions, indicated Resident R2 had two unstageable pressure ulcers with slough and/or eschar, and further indicated that neither of the pressure ulcers were present upon admission. Review of Resident R2's admission MDS dated [DATE], Section GG: Functional Abilities indicated Resident R2 was Dependent on staff to roll left and right, to move from a sitting to a lying position, to move from a lying position to a sitting position, moving from a sitting position to a standing position, and to transfer between a chair and the bed. Review of Section M: Skin Conditions, indicated that Resident R2 did not have any pressure injuries at the time of the admission assessment. Review of Resident R2's admission Observation dated 11/12/25, indicated that Resident R2 had no skin alterations upon admission. Review of Resident R2's Braden Scale assessment dated [DATE], indicated that Resident R2 was at high risk of pressure ulcer development. Review of the plan of care dated 11/12/25, for Potential for Alteration in Skin Integrity indicated that staff should assist with weight position changes throughout the day and night. Review of a progress note dated 3/9/26, indicated that Resident R2 had no new skin issues. Review of a progress note dated 3/11/26, indicated that Resident R2 had a reopened hematoma on her right hip that measured 1.4cm x 1cm x 0.1cm and a left hip unstageable wound that measured 3 cm x 2.2 cm.Review of a progress note dated 3/11/26, at 10:27 a.m. Resident R2 was assessed on wound rounds. Recommended Manuka honey and foam dressing MWF. Review of a progress note dated 3/18/26, at 11:29 a.m. Resident R2 was assessed on wound rounds with a recommendation for Santyl (prescription wound ointment) and foam dressing MWF for left hip, Cavilon (skin protectant film) for right hip. Further review of progress notes failed to reveal an assessment of wounds completed by a medical doctor or nurse practitioner between discovery of the wound on 3/11/26, and 3/25/26. Review of a wound nurse practitioner's note dated 3/25/26, indicated facility staff requested an evaluation of Resident R2's bilateral unstageable pressure ulcers, which were acquired at the SNF (skilled nursing facility) and noticed 3/11/26 per staff. The note further stated that the WCN (wound care nurse) was unsure of the cause of the wounds. Wound measurements were: Right hip: 1.6 cm x 2.4 cm x 0.2 cm.Left hip: 1.4 cm x 2.3 cm x 2.5 cm. Review of a wound nurse practitioner's note dated 4/1/26, indicated that wound measurements were: Right hip: 1.9 cm x 1.7 cm x 0.2 cm.Left hip: 0.8 cm x 2.3 cm x 3.1 cm. Review of a wound nurse practitioner's note dated 4/8/26, indicated that wound measurements were: Right hip: 1.7 cm x 1.2 cm x 0.2 cm.Left hip: 1.2 cm x 0.8 cm x 3.0 cm. Review of a wound nurse practitioner's note dated 4/15/26, indicated that wound measurements were: Right hip: 1.7 cm x 0.9 cm x 0.4 cm.Left hip: 0.9 cm x 0.8 cm x 2.5 cm. Review of a wound nurse practitioner's note dated 4/22/26, indicated that wound measurements were: Right hip: 1.2 cm x 1.2 cm x 0.5 cm.Left hip: 0.9 cm x 1.3 cm x 2.8 cm, with a notation that the wound was deteriorating. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a wound nurse practitioner's note dated 4/29/26, indicated that wound measurements were: Right hip: 2.2 cm x 1.6 cm x 0.5 cm with a notation that the wound was deteriorating.Left hip: 0.7 cm x 0.8 cm x 2.5 cm, with a notation that there was undermining (tissue erosion underneath the outwardly visible wound margins), that the wound had a strong odor, and that the wound was deteriorating. Review of a progress note dated 4/29/26, ay 10:07 a.m. indicated, Resident seen by wound care team today. Resident has purulent drainage to left hip wound with odor. Wound culture collected. Review of a progress note on 5/5/26, indicated that three different bacteria were present in Resident R2's wound cultures. Review of a progress notes dated 5/5/26, indicated Resident R2 was provided with her first dose of antibiotics related to her hip wound. Review of a wound nurse practitioner's note dated 5/6/26, that wound measurements were:Right hip: 1.8 cm x 2.2 cm x 0.8 cm with a notation that the wound was deteriorating.Left hip: 1.0 cm x 1.5 cm x 2.5 cm, with a notation that there is undermining present. Review of a progress note dated 5/11/26, at 10:34 a.m. indicated Resident R2's wounds to remained reddened and foul smelling, with a moderate amount of purulent drainage (commonly known as pus). Review of a wound nurse practitioner's note dated 5/13/26, that wound measurements were:Right hip: 2.1 cm x 1.7 cm x 0.8 cm with a notation that there was undermining present and that the wound was deteriorating.Left hip: 1.0 cm x 1.3 cm x 2.5 cm, with a notation that there was undermining present, a large amount of drainage with an odor, and that the wound was deteriorating. Review of a progress note dated 5/13/26, at 1:11 p.m. indicated that Resident R2 was sent to the hospital for worsening wounds. Review of emergency room notes dated 5/13/26, indicated: Resident R2 was treated for dehydration in the setting of sepsis and was placed on broad-spectrum antibiotics. On my exam looked volume depleted with decreased skin turgor (skin's elasticity and its ability to change shape and snap back to its normal position). Patient blood pressure stabilized after receiving 1.5 L (liters) of LR (an isotonic, sterile intravenous fluid used to rapidly replace water and electrolytes in cases of dehydration, blood loss, or shock), the infection source is likely from her chronic bilateral hip wound that is concerning for either soft tissue infection or osteomyelitis (inflammation of bone or bone marrow, usually due to infection) pending further imaging and plastic evaluation. Does appear to be in pain and cries out when her hips are palpated. Review of a hospital note dated 5/15/26, indicated the infectious source would likely be bilateral hip wound, and noted purulence from the left side. Resident R2 continued on Vancomycin (a potent antibiotic used to treat serious, hard-to-treat bacterial infections) and Cefepime (broad-spectrum antibiotic used to treat moderate-to-severe bacterial infections). Review of a plastic surgery consultation note dated 5/13/26, indicated: L Hip wound: 2x2 cm wound over L hip. Wound bed with necrotic tissue. Tracks approx. 4 cm deep along lateral aspect. Could not palpate bone. Purulent drainage appreciated.R Hip wound: 2 x 2 cm wound over R hip with some necrotic tissue appreciated. No visible bone. Review of facility provided documentation on 5/16/26 indicated that on 5/4/26, the facility confirmed that the facility was in non-compliance with pressure ulcer care requirements. During an interview on 5/26/26, at 1:30 p.m., the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to develop and implement care and services consistent with professional standards of practice to prevent the new development of pressure ulcers that resulted in hospitalization for the treatment of wounds. This resulted in actual harm for two of three residents with facility-acquired pressure ulcers. 28 Pa. Code 211.10(c)(d) Resident care policies28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on a review of facility documents, observations, and staff interview, it was determined that the facility failed to maintain an effective call system for 15 of 17 residents (Resident R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, and R14).Findings include: Review of the Facility Assessment last reviewed 2/9/26, indicated the facility is equipped with a nurse call system. During an observation on 5/16/26, at 10:02 a.m. of the shared restroom for Residents R1, R2, R3, and R4, revealed that the call light cord for was wrapped so tightly around the handrail it was unable to be alarmed. During an observation on 5/16/26, at 10:06 a.m. of the shared restroom for Residents R5, R6, and R7, revealed that the call light cord for was wrapped so tightly around the handrail it was unable to be alarmed. During an observation on 5/16/26, at 10:16 a.m. of the shared restroom for Residents R8, R9, R10, and R11, revealed that the call light cord for was wrapped so tightly around the handrail it was unable to be alarmed. During an observation on 5/16/26, at 10:19 a.m. of the shared restroom for Residents R12, R13, and R14 revealed that the call light cord for was wrapped so tightly around the handrail it was unable to be alarmed. During an interview on 5/26/26, at approximately 1:30 p.m. the Nursing Home Administrator confirmed that the facility failed to maintain an effective call system for 14 of 17 residents. 28 Pa Code 201.14 (a) Responsibility of licensee.28 Pa Code 201.18 (b)(1) Management.28 Pa Code 204.11 (b) Equipment for Bathrooms.