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	06/06/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51307 Based on review of facility policy and documents, clinical record review, resident, and staff interviews, it was determined that the facility failed to make certain that necessary care and services were provided for two of ten residents (Resident R17 and R400). Findings include: Review of the facility policy All Policy and Procedure: General Guidelines reviewed 1/07/25, indicated to provide the necessary care and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being in accordance with their comprehensive person-centered plan of care that is culturally-competent and trauma informed. The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated that a BIMS (Brief Interview of Mental Status) is a brief screener that aids in detecting cognitive impairment. Scores from a BIMS assessment suggests the following distributions: 13 - 15: cognitively intact 8 - 12: moderately impaired 0 - 7: severe impairment Review of the clinical record indicated Resident R17 was admitted to the facility on [DATE], with diagnoses that included cerebral infarct (stroke), aphasia (difficulty to speak) stroke related, and hemiparesis (reduced ability to move) stroke related. Review of the Minimum Data Set (MDS - comprehensive, standardized assessment of each resident's functional capabilities and health needs) dated 4/09/25, indicated the diagnoses remain current. Resident R17 has a BIMS of 00 and Section GG 130 personal hygiene indicates resident is dependent, caregiver does all of the effort or requires assistance of two or more for care. During an observation on 6/02/25, at 11:28 a.m. Resident R17 was observed to have long, unkempt fingernails. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record indicated Resident R400 was admitted to the facility on [DATE], with diagnoses that included cerebral infarct (stroke), dysarthria (slurred speech) stroke related, and heart failure. Review of the MDS dated [DATE], indicated the diagnoses remain current. Resident R400 has a BIMS of 14 and Section GG 130 personal hygiene indicates resident requires substantial/maximal assistance, caregiver provides more than half the effort for care. During an interview and observation on 6/02/25, at approximately 11:40 a.m. Resident R400 had noticeable facial hair growth on the chin and upper lip area, resembling a goatee. When asked, Resident R400 nodded yes and verbalized she would like assistance in removing her facial hair. During an interview on 6/2/25, at 12:05 p.m. Employee E10 RN confirmed the above findings. During an interview on 6/4/25, at 1:00 p.m. The Nursing Home Administrator confirmed the above findings, and that the facility failed to make certain that necessary care and services were provided for two of ten residents (Resident R17 and R400). 28 Pa. Code: 211.12(1) Nursing services. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12 (2)(5) Nursing services.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on a review of scheduled activities, observations, and staff interviews, it was determined that the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of residents on one of five nursing units (Nursing Unit 3B). Findings include: Review of the activities calendars for Nursing Unit 3B (secure unit for residents with dementia) from January through June 2025 revealed each weekend had one activity on 24 of 26 Saturdays, and 23 of 25 Sundays the only activity was Social Visits. Review of the Activities calendar for June 2025 revealed the following: 6/15/25: Donuts for Dads 6/16/25: Afternoon Painting 6/17/25: Fine Art Miracles: Music and Movement 6/18/25: Morning Exercise 6/19/25: Juice Break 6/20/25: First Day of Summer Social 6/21/25: Nail Salon During an observation on 6/2/25, at 10:53 a.m. there were approximately 18 residents in the dining room. A movie was playing on the television, which one resident appeared to be watching. One staff member was seated against the wall, not interacting with the residents. During an observation on 6/3/25, between 1:30 p.m. and 1:43 p.m. Nurse Aide (NA) Employee E18 identified all the residents attending Bingo on the second floor. Review of unit census sheets confirmed all the residents that attended resided on the second floor. NA Employee E18 confirmed that residents from Nursing Unit 3B did not attend activities on the second floor. During an observation on 6/3/25, at 1:45 p.m. 20 residents were present in the dining room/lounge on the third floor. The movie [NAME] in Wonderland was playing on the television, which one resident appeared to be watching. One staff member was seated at a table, not interacting with the residents, using a tablet. During an observation on 6/4/25, at 9:53 a.m. 18 residents were present in the dining room/lounge on the third floor. Golden Girls was being played on the television. No activities were occurring. No staff members were interacting with the residents. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 6/4/25, at 10:23 a.m. no activities were occurring in the dining room/lounge. Two staff members were present, having a personal conversation between themselves. No staff members were interacting with the residents. During an observation on 6/4/25, at 10:30 a.m. one additional staff member entered the dining room/lounge and began using a computer on wheels. No staff members were interacting with the residents. During an observation on 6/4/25, at 10:35 a.m. the Wizard of Oz began playing on the television, and multiple residents were moved into position to watch it. During an observation on 6/5/25, at 9:40 a.m. 22 residents were present in the dining room/lounge on the third floor. Golden Girls was being played on the television. No activities were occurring. During an observation on 6/5/25, at 10:15 a.m. nursing staff dimmed the lights in one side of the room, and spoke of putting a movie on. During an observation on 6/5/25, at 10:20 a.m. Recreation Assistant Employee E19 began setting up for an activity in a smaller resident lounge. During an interview on 6/5/25, at 10:25 a.m. Recreation Assistant Employee E19 confirmed the week of 6/15/25, through 6/21/25, had minimal activities due to her being on vacation. When asked why the Target Toss activity scheduled on 6/4/25, did not occur, Recreation Assistant Employee E19 stated it was due to the residents being taken outside. When asked which residents went, Recreation Assistant Employee E19 provided two names. When asked, Recreation Assistant Employee E19 confirmed that only two of the 37 residents on the unit were provided an activity on the morning of 6/4/25. During an interview on 6/5/25, at 1:04 p.m. Activities Director Employee E20 confirmed that on weekends the residents were only provided one activity per day. Activities Director Employee E20 stated that she is not able to have additional staff to assist in covering vacations unless there are other staff on modified duty who are available to help. During an interview on 6/6/25, at approximately 10:30 a.m. the Nursing Home Administrator confirmed the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of residents on one of five nursing units. 28 Pa. Code: 201. 18(b)(3) Management. 28 Pa. Code: 207.2(a) Administrators Responsibility.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **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 assess, document, and notify physicians of increased and decreased Capillary Blood Glucose (CBG) levels for three of nine residents reviewed (Residents R8, R45, and R154), and the facility failed to appropriately respond to a resident's change in condition for one of four residents (Resident R146). Findings include: The Centers for Disease Control defines diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 milligrams per deciliter (mg/dl). If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours, or a blood glucose greater than 180 mg/dL one to two hours after eating. If you have hyperglycemia and it's untreated for long periods of time, you can damage your nerves, blood vessels, tissues and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage and non-healing wounds. Review of the facility policy General Guidelines regarding Nursing care reviewed 1/7/25, indicated the nurse must verify all practitioners orders to ensure all required information/directions are included. Staff must monitor the resident ' s status and condition and respond to significant changes promptly. Staff must document all care and services provided to the resident. Notifies physician of changes, assessment findings and secures treatment and diagnostic direction and orders from the physician. Documents findings and notifications in the nurses notes. Review of the facility policy Notification of Change in Resident Condition and Treatment Changes reviewed 1/7/25, indicated to assess resident's condition including dialogue with the resident and evaluation of findings. Review of the User Guide for Contour Next EZ blood glucose monitoring system indicated under Test Results a Caution: HI results are greater than 600. The facility was unable to provide policies regarding care of a diabetic resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of information provided by the Mayo Clinic dated 10/8/22, indicated that, A normal resting heart rate for adults ranges from 60 to 100 beats per minute. Review of information provided by the Mayo Clinic dated 5/17/22, indicated a normal blood sodium level is between 135 and 145 milliequivalents per liter (mEq/L). Review of National Institute of Health information titled, Dehydration dated June 2020, defined dehydration as a condition caused by the loss of too much fluid from the body. In the Who is more likely to develop dehydration section, the first entry was older adults. Further within the document indicated to get medical help right away if a person has a rapid heartbeat. Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE], with diagnoses that included diabetes, dementia (group of symptoms affecting memory, thinking and social abilities), and depression. Review of Resident R8' s Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 5/21/25, indicated the diagnoses remain current. Review of Resident R8 physician's order revealed the following orders: - Accucheck every morning. If blood sugar less than 60 and symptomatic or greater than 400 call MD (doctor) - Lantus (long-acting type of insulin that works slowly, over about 24 hours) 28 units in morning. - Novolog (a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about one hour, and keeps working for two to four hours) two units with meals - Review of the clinical record, and electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: - On 2/28/25, at 10:18 a.m. the CBG was noted to be HI. Review of the care plan dated 6/17/24, indicated the following interventions: - Administer medications per MD order. - Monitor for signs and symptoms of hyper/hypoglycemia. - Accuchecks as needed. Notify MD for hypoglycemic/hyperglycemic episodes per order. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, the blood glucose was not monitored for effectiveness of treatment, staff failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed date. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a clinical record indicated Resident R45 was admitted to the facility on [DATE], with diagnoses that included diabetes, high blood pressure, and seizure disorder (abnormal electrical activity in your brain that temporarily causes changes in awareness and muscle control, behavior and senses). Review of the MDS dated [DATE], indicated the diagnoses remain current. Review of Resident R45 physician's orders revealed the following orders: - On 7/23/24 through 2/25/25, Lispro (a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about one hour, and keeps working for two to four hours) two units with meals. - On 8/5/24 through 2/25/25, Lispro per sliding scale. If blood sugar is less than 60, and resident is symptomatic or greater than 400 call MD. Four times a day before meals and at bedtime. - On 11/14/24 through 3/4/25, Lantus six units once a day in AM (morning). - On 2/25/25, Aspart (a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about one hour, and keeps working for two to four hours) - On 4/18/25, Aspart per sliding scale. If blood sugar is less than 60 and resident is symptomatic or greater that 400 call MD. Review of Resident 45's eMAR revealed that the resident's CBG's were as follows: - On 1/14/25, at 7:18 p.m. the CBG was noted to be HI. - On 5/27/25, at 3:36 p.m. the CBG was noted to be 59. Review of the care plan dated 6/17/24, indicated the following interventions: - Administer medications per MD order. - Monitor for signs and symptoms of hyper/hypoglycemia. - Accuchecks as needed. Notify MD for hypoglycemic/hyperglycemic episodes per order. Review of Resident R45's eMAR and clinical progress notes indicated the resident was not assessed for hyper-/hypoglycemia, the blood glucose was not monitored for effectiveness of treatment, staff failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed dates. Review of the clinical record indicated Resident R154 was readmitted to the facility on [DATE], with diagnoses that included diabetes, depression, and dementia. Review of the MDS dated [DATE], indicated the diagnoses remain current. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R154 physician's order revealed the following orders: - Accucheck every morning. No coverage but if blood sugar less than 60 and symptomatic or greater than 400 call MD twice a day. Review of the clinical record, and electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: - On 11/4/24, at 8:11 p.m. the CBG was noted to be HI. Review of the care plan dated 1/30/24, indicated the following interventions: - Administer medications per MD order. - Monitor for signs and symptoms of hyper/hypoglycemia. - Accuchecks as needed. Notify MD for hypoglycemic/hyperglycemic episodes per order. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, the blood glucose was not monitored for effectiveness of treatment, staff failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed date. During an interview on 6/5/25, at 10:00 a.m. Licensed Practical Nurse (LPN) Employee E11 stated it depends on the resident ' s order for when to notify the doctor. If the blood sugar was below 70, they would provide juice or snack depending on their signs and symptoms. If the blood sugar was greater that 250, they would give the resident water, the ordered insulin, and is signs and symptoms were present, they would notify the doctor. They stated that each resident should have individualized orders for diabetic care, if necessary. During an interview on 6/5/25, at 10:05 a.m. Registered Nurse (RN) Employee E12 stated it would depend on the signs and symptoms and the resident ' s ordered parameter. They would assess the resident, check the parameters, and give the necessary intervention (snack or ordered insulin). They would report any vital out of range result and the computer charting system prompts the user to make a progress note. During an interview on 6/5/25, at 10:08 a.m. RN Employee E13 stated if the blood sugar was less that 70 or over 250, they would follow the ordered parameters to when to notify the doctor. If the blood sugar was less than 70, they would provide a snack or juice and recheck the blood sugar in 15 minutes. If the blood sugar was over 400, they would give the ordered insulin and encourage the resident to drink water. They would re-assess the resident in 30 minutes. During an interview on 6/5/25, at 10:10 a.m. LPN Employee E14 stated they would assess the resident, if the blood glucose was elevated, they would encourage water, give the ordered insulin, assess the resident, call the doctor, and monitor the resident. If the blood sugar was low, they would provide juice or a snack, tell the supervisor, and reassess the resident in 30 minutes. They would document in the progress notes. They stated that the medical record charting flags the resident for reassessment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/25, at 10:15 a.m. RN Employee E15 stated she would assess the resident for signs and symptoms of hypo-/hyperglycemia and check the resident ' s orders. If the blood sugar was less than 70, they would provide a snack, orange juice, or peanut butter, and recheck the blood sugar within an hour. If the blood sugar was greater than 350-400 they would check the ordered parameters, and notify the doctor if needed. They would document in the progress notes, and eMAR. During an interview on 6/5/25, at 10:20 a.m. LPN Employee E16 stated they would be concerned if the resident ' s blood sugar was less than 70, or greater than 120. They would check the orders for parameters, assess the resident for signs and symptoms of hypo-/hyperglycemia. They would document on the doctor ' s board in the facility, in the progress notes, and they would document the reassessment. During an interview on 6/5/25, at 10:25 a.m. LPN Employee E17 stated they would check the resident ' s orders for the parameters. If the blood sugar was less than 70, they would check the orders and provide a snack or juice. If the blood sugar does not increase after the intervention, they would notify the doctor. If the blood sugar was over 400, the would check the ordered parameters, give the ordered insulin, recheck in five to ten minutes, and call the doctor if needed. They would document in the eMAR, and they would notify the RN supervisor on duty. During an interview on 6/5/25, at 1:00 p.m. the Director of Nursing confirmed the facility failed to notify the doctor of a change in condition, failed to document an assessment or interventions used related to blood glucose, and failed to follow physicians orders for Residents R8, R45, and R154. Review of the clinical record indicated Resident R146 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior) and pulmonary hypertension (a type of high blood pressure that affects arteries in the lungs and in the heart). Review of Resident R146's Potential for alteration in nutrition/dehydration care plan initiated 5/6/24, indicated for staff to Monitor fluid intake on an ongoing basis and assess for signs and symptoms of dehydration. Review of Resident R146's heart rate record indicated the highest blood pressure assessed from admission (5/6/24) to 2/22/25, indicated on 1/25/25, Resident R146's heart rate was 90 beats per minute, on 12/10/24, Resident R146's heart rate was 94 beats per minutes, and the remainder of the assessments (94) were below 90 beats per minutes. Review of Resident R146's heart rate record from 2/26/25, through 2/28/25, revealed: 2/28/25, 1:55 a.m. Pulse: 137 per minute 2/28/25, 1:49 a.m. Pulse: 150 per minute 2/27/25, 8:22 p.m. Pulse: 138 per minute 2/27/25, 1:57 p.m. Pulse: 126 per minute (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/27/25, 1:22 p.m. Pulse: 125 per minute 2/26/25, 2:34 p.m. Pulse: 100 per minute 2/26/25, 8:44 a.m. Pulse: 110 per minute Review of a progress note dated 2/17/25, at 9:42 p.m. indicated, CNA (nurse aide) informed this writer of blood in brief upon observation small pink tinged area to rear side of soiled brief along with small pink tinged area to wash cloth noted. Review of a progress note dated 2/20/25, at 1:26 p.m. indicated, [Psychiatrist] made aware of resident increase irritability, aggression, agitation. Resident is a two persons caregiver due to her aggressive behavior. Review of a progress note dated 2/20/25, at 4:01 p.m. indicated, Staff called this writer to the room to assist with getting resident into her w/c (wheelchair), stating resident physical aggression escalate as the two caregivers attempt to get resident washed & dressed, resident is two persons caregivers due to her physical aggression, verbal aggression, per staff resident was kicking CNA R (right) knee, choking one of the CNA then grabbed her chest, hitting staff in the face, grabbing CNA neck, grabbing staff breasts causing her breasts to bleed. Staff stated they gave resident time to deescalate, then proceed to get her into her w/c. Resident self-inflicted and re-open a skin tear to her R shin. Area cleanse & dress with band aid. Alert [Psychiatrist] of resident increase agitation. Review of a progress note dated 2/21/25, at 12:01 p.m. indicated, This writer in to assist staff with routine AM care, observed resident using her right hand digging her nails into CNA #1 arm, after staff asked resident to let go of the arm, she took a full swing with her left arm to CNA #2 chest, staff position resident on her side so caregivers can pulled the dirty brief's out to give resident peri care, she used her right leg to kick staff but missed, resident is very quick with her arms & hands, always reaching out to hit, punch, kick, or digging her hands to hurt staff. Resident was medicated with Olanzapine 5MG (antipsychotic medication) prior to care, meds are not effective, unable to redirect resident. [Psychiatrist] is aware of resident behaviors, will be here next week to exam resident. Review of a progress note dated 2/24/25, at 9:31 a.m. indicated, Received orders from [Psychiatrist] CBC-CMP-TSH-UA C&S (blood laboratory tests and a urinalysis with culture and sensitivity testing). Resident is incontinent. Straight cath (one time catheterization) if unable to obtain urine via clean catch. Acetaminophen (Tylenol) 650 MG PO BID DX: pain (by mouth, twice daily for pain). Review of a progress note dated 2/24/25, at 11:15 a.m. indicated, N/O (new order) received start Olanzapine 7. 5MG in AM give prior to care & Olanzapine 5MG in PM. One time order for Ativan 0.5MG (anti-anxiety medication) give prior to straight cath. Review of a progress note dated 2/24/25, at 1:49 p.m. indicated, Straight Cath using sterile technique with immediate return of yellow urine. Assist of 4 staff to obtain urine specimen. Ativan somewhat effective. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note dated 2/25/25, at 1:36 p.m. indicated, Staff reported resident with less aggression noted during AM care. Observed resident talking to herself today in the dining room then took her finger pointing to the table questionable if resident is hallucinating. Olanzapine 7. 5MG was started this AM. Will continue to monitor for adverse reaction. Review of a progress note dated 2/26/25, at 2:03 a.m. indicated that the urine sample results are still pending. Review of a progress note dated 2/26/25, at 8:45 a.m. indicated, Resident on charting for increase in Olanzapine 7. 5MG PO in AM. Observed resident with shakiness, stiffness, difficulty with speech, somnolence. Alert MD (doctor of medicine) of noticeable side effects of meds. MD will be in today. Meds held as per nursing measures. Review of a progress note dated 2/26/25, at 1:15 p.m. indicated, [Psychiatrist] in assessed resident due to increase in Olanzapine 7. 5MG in AM started yesterday 2/25. Due to adverse side effects, med was discontinued. N/O decrease Olanzapine 5MG PO BID. Meds held today due to resident having difficulty with her speech, stiffness, somnolence, unable to swallow. Resident did poorly for breakfast, but did manage to consume mostly liquid for lunch, she ate all her pudding. Will continue to monitor & hold meds if she is sedated. Review of a progress note dated 2/26/25, at 2:35 p.m. indicated, Recheck apical pulse now 100. Review of a progress note dated 2/26/25, at 9:40 a.m. indicated, Received a call from [laboratory provider] stating that the collection tube was incorrectly filled and required recollection. Obtained new urine sample using sterile technique. Review of a progress note dated 2/27/25, at 10:57 a.m. indicated the resident started a new order for Ciprofloxacin 500 mg. Review of a progress note dated 2/27/25, at 1:24 p.m. indicated, Resident accept Cipro with much cueing, combative-aggressive while attempt to administer meds. Unable to redirect. HR (heart rate) remains above 120, attempt several times to retake HR, no changes noted. Review of a progress note dated 2/27/25, at 8:29 p.m. indicated, Resident's nurse notified, and supervisor notified about HR. Already aware and Dr aware. Review of a progress note dated 2/28/25, at 1:50 a.m. indicated, peripheral pulse taken while patient was sleeping soundly, snoring, offering no resistance 150. Review of a physician's note dated 2/28/25, at 5:02 a.m. indicated, [Resident R146] is seen in follow-up. She has had delirium of late with a change of mental status. She has been very aggressive towards staff. She has underlying anxiety and she had been ordered a urine study which shows positive nitrites, leukocyte esterase, and many bacteria. She does get delirious with the urinary tract infections typically. She has a history of left humerus fracture and left ulna fracture. She flows (flails) her arms when she gets anxious or delirious from a UTI (urinary tract infection). (continued on next page)

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	395643	A. Building B. Wing	06/06/2025

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note dated 2/28/25, at 8:16 a.m. indicated, Resident is being sent to [hospital] for eval. Her heart rate has been elevated with increased confusion. VSS 97.6, 114/76, 161, 95% RA, 17 RR. Resident is in NAD (no apparent distress), but MD wanted an EKG (electrocardiogram, a test that records the electrical signals in the heart, helping to check the heartbeat and diagnose various heart conditions) which was not successful yesterday due to resident being combative and removing leads. Review of a progress note dated 2/28/25, at 8:34 p.m. revealed Resident R146 was admitted to the hospital for a urinary tract infection and dehydration. Review of a progress note dated 3/3/25, at 4:18 p.m. revealed Resident R146 returned to the facility at approximately 3:00 p.m. Review of hospital documentation dated 3/3/25, indicated Resident R146 was treated for: -Urinary tract infection with hematuria (blood in the urine). Patient is a permanent resident of [the facility]. Patient was started on Cipro (ciprofloxacin) on 02/27 for UTI. Unfortunately, the facility did not send urine culture. Urine culture negative but may be skewed by antibiotics will complete treatment. Received vanco (vancomycin, an antibiotic medication) and cefepime (an antibiotic medication) in the emergency room . -Hypernatremia (elevated blood sodium). Likely due to poor intake / severe dehydration. Sodium 153 on admission. Much improved status post aggressive IV (intravenous) hydration. -A-fib (atrial fibrillation, disease of the heart characterized by irregular and often faster heartbeat). Tachycardic likely AFib with RVR (rapid ventricular response) with dehydration. Rate improving. During an interview on 6/6/25, at approximately 10:30 a.m. the Nursing Home Administrator and the Director of Nursing were made aware of concern related to the delay of care in treating Resident R146's initial sign of a urinary tract infection (blood in the brief) and subsequent hospitalization . During this interview, the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to assess, document, and notify physicians of increased and decreased CBG levels for three of nine residents reviewed. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 201.29(a) Resident rights. 28 Pa. Code: 201.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31343 Based on review of facility documents, clinical record review, and staff interviews, it was determined that the facility failed to provide adequate supervision to prevent a resident from falling from the wheelchair, for one of three residents (Resident R32). Findings include: Review of the facility policy Incident Report dated 1/7/25, indicated it is the facility's policy to provide resident safety and to investigate and report all incidents and initiate appropriate care and services to residents. During an interview on 6/2/25, at 1:05 p.m., the Nursing Home Administrator stated that the facility does not have a policy for transporting residents as it is not required. The residents who propel themselves in wheelchairs are not provided leg rests from therapy as they would be in the way and would not allow residents to maintain their independence. Review of the clinical record indicated that Resident R32 was admitted to the facility on [DATE], with diagnoses which included dementia, anxiety, blindness difficulty walking, cognitive deficit and communication deficit and agitation. Resident R32 is on blood thinners. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 3/14/25, Section G0110 Functional Status identified an attachment for Section GG Therapy Data Report which identified Resident R32 requiring a manual wheelchair and identified that Resident R32 required partial to moderate assistance to move the wheelchair 50 feet. Review of Resident R32's Occupational Therapy encounter notes dated from 5/5/25, through 5/27/25, indicated that Resident R32 had to be adjusted numerous times for lateral supports due to her leaning to either side and falling asleep in her wheelchair. Review of a facility provided document dated 5/27/25, indicated Nurse Aide(NA) Employee E1 attempted to redirect Resident R32's wheelchair from behind and Resident R32 put her feet down and fell out of her wheelchair. Review of the statement dated 5/27/25, from NA Employee E1, Resident R32 put her feet down when NA Employee E1 attempted to straighten her wheelchair towards Resident R32's room and the wheelchair went fast and the resident was on the floor. Review of progress note dated 5/27/25, at 9:42 p.m., by Licensed Practical Nurse Employee E2 indicated NA was pushing resident's wheelchair to change her brief. Resident put her feet down causing her to lean forward and fell . Review of Resident R32's plan of care prior to the incident was not able to be produced, however, the current plan of care identified the use of leg rests. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/2/25, at 1:02 p.m., the Nursing Home Administrator(NHA) and Director of Nursing(DON) stated that after review of the CCTV video on this date, it appeared that the Nurse Aide continued to push the resident after her feet were down and resident fell forward from wheelchair. The NHA stated that the therapy department does not provide every resident with leg rests if identified that they can propel themselves. Review of the telephone interview from NA Employee E1 on 6/2/25, at 1:15 p.m., documented by the DON indicated that the nurse aide stated that she was pushing her and her feet were up then dropped and she stopped, however, the resident fell forward. During a telephone interview on 6/2/25, at 3:26 p.m., NA Employee E1 stated that she was attempting to take Resident R32 to her room to change her and she was pushing her wheelchair as Resident R32 cannot propel herself, and Resident R32 put her feet down and fell forward from the wheelchair. NA Employee E1 stated that she had asked about leg rests for Resident R32's wheelchair and was told she does not have any. NA Employee E1 stated that other staff stated they roll her backwards. NA Employee E1 indicated that the kardex(information in the electronic record identifying resident care needs) is where each residents information is located to identify each residents specific needs and she had access to Resident R32's information. During an interview on 6/4/25, at 8:45 a.m., Licensed Practical Nurse Employee E3 stated that she has been at the facility and has worked on the unit where Resident R32 resides and that Resident R32 has never been able to propel herself. During an interview on 6/2/25, at 1:02 p. m., the NHA confirmed that the facility failed to provide adequate supervision to prevent a fall from a wheelchair for one of three residents (Resident R32). 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43725 Based on observations and staff interview, it was determined that the facility failed to properly restrain hair to prevent the potential for cross contamination in the Main Kitchen. Findings include: Review of facility policy Use of Hair Restraints reviewed 1/7/25, indicated hair nets, baseball caps, chef hats, and/or mustache/beard restraints must be worn when any employee is in the food production and kitchen area. Hair restraints and mustache/beard guards must be worn to cover all visible hair. During an observation on 6/4/25, at 11:09 a.m. Food Service Worker Employee E4, Food Service Worker Employee E5, and Food Service Supervisor Employee E6 were observed in the kitchen without beard restraints. During an observation on 6/4/25, at 11:23 a.m. Dietary Manager Employee E7 was observed in the kitchen without a beard restraint. During an observation on 6/4/25, at 11:44 a.m. [NAME] Employee E8 was observed with a hair net on the crown of her head, not covering the front three inches of hair from forehead back. During an observation on 6/5/24, at 9:40 a.m. [NAME] Employee E8, and Dietary Aide Employee E9 were observed in the kitchen with a hair net on, not covering the front two or three inches of hair from forehead back. [NAME] Employee E8 stated, My bad, you caught me again. During an interview on 6/4/25, at 11:25 a.m. the Dietary Manager Employee E9 confirmed the kitchen staff should wear hair nets to cover all hair and/or mustache/beard restraints, if facial hair is present. 28 Pa. Code: 211.6(c)(d)(f) Dietary services.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 39311 Based on review of facility assessment, personnel file reviews, and staff interviews, it was determined that the facility failed to implement, and maintain an effective training program for individuals providing services under contractual arrangement, consistent with their expected roles. Findings include: Review of the Facility Assessment reviewed 4/9/25, indicated, All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care. Included in the list of education provided to new hires, facility staff, contracted staff, and volunteers - as applicable to role in facility were; -Resident Rights -Resident Abuse and Suspicion of a Crime -Compliance, HIPAA, Code of Conduct, and Ethics -Infection Prevention and Control -Psychosocial Needs -Dementia - Positive Approach -Emergency Preparedness and Fire Safety -Accident Prevention and Risk Management -Communication and Customer Service -QAPI - Mission , Vision, Values -Person Centered Care -Trauma Informed Care -Behavioral Health -HR Policy Review of the facility policy In-Service Training dated 1/7/25, indicated the policy applies to all employees, contractual staff, and volunteers. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/6/25, at 9:49 a.m., the Nursing Home Administrator was asked to provide all required training records for the contracted Nursing Staff. Training records were not provided to the survey team for the Contracted Nursing Staff. During an interview on 6/6/25, at 9:49 a.m., the Nursing Home Administrator confirmed the facility failed to implement, and maintain an effective training program for individuals providing services under contractual arrangement, consistent with their expected roles. 28 Pa. Code 201.20(a)(b)(c)(d) Staff development.