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	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John J Kane Regional Center-Gl	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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, facility provided documents and clinical records, and staff interviews, it was determined that the facility failed to protect residents from abuse and neglect which resulted in actual harm of a fracture of the right tibia (lower leg bone) for one of four residents (Resident R86). This deficiency is cited as past non-compliance.Findings include: Review of the facility policy, Abuse-Resident and Reasonable Suspicion of a Crime dated 6/13/26, and previously reviewed 6/30/25, 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 programs. This policy also provides direction to staff regarding procedures required to protect residents from abuse, to respond appropriately to allegations, to satisfy reporting and notifications obligations, and to conduct investigations. For purpose of this policy staff include facility employees, practitioners, consultants, contractors, volunteers, and students who provide care and services to residents in the facility. Review of the facility policy, Accident Prevention dated 6/13/26, and previously dated 6/30/25, indicated [NAME] Community Living Centers will prevent accidents and injuries to the extent possible by maintaining as much as possible, an environment free from accident hazards and by assuring residents receive adequate supervision and assistive devices to prevent accidents. To safeguard all residents and employees, the facility reserves the right to discharge any residents who willfully and/or repeatedly disregards facility rules and places his/herself and others in danger. Review of the admission record indicated Resident R86 was admitted to the facility on [DATE]. Review of Resident R86's Minimum Data Set (MDS-a periodic assessment of care needs) dated 5/28/26, indicated the diagnoses of high blood pressure, vascular dementia (decline in thinking and memory skills caused by conditions that block or reduce blood flow to the brain, depriving it of vital oxygen and nutrients), muscle weakness, and cognitive communication deficit (impairment in communication caused by disrupted brain functions like attention, memory, and executive functioning, rather than a primary speech or language disorder). Section GG0170-Mobility: (Roll left to right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer) is coded as 01, (01-indicating dependent), Walk 10 feet is coded 09, (09-Not applicable-not attempted and resident did not perform this activity prior to current illness, exacerbation, or injury) Functional Abilities-utilizes a wheelchair. Review of Resident R86's care plan initiated 3/20/25 (1), and updated 5/18/26 (2) indicated: -Focus (1): Resident will have all necessary assistance with ADL's-may move around the facility without supervision but may not exit the facility without supervision. -Focus (2): Bruising bilateral lower extremities, swelling lower right ext. will resolve, fracture of right tibia will not worsen. Resident R86 placed on bed rest, Hoyer for all transfers with two caregivers. Review of an incident note dated 5/18/26, at 1:40 p.m. indicated Resident R86 presented with bruising and swelling to the right lower extremity. Bruising was documented on 5/16/26 on the 3-11 shift. CCTV (closed circuit television) review for 5/15/26, 3-11 shift showed agency nurse aide (NA) pulling Resident R86 who was caught in the doorway out. When NA attempted (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 0600 Level of Harm - Actual harm Residents Affected - Few	to push her in the doorway forcefully, Resident R86's right foot got caught on the doorframe striking her right shin then her left shin, then the NA pushed her through the doorway. Review of progress notes revealed no notes from 5/15/26, and 5/16/26. Review of progress notes from 5/17/26, at 11:35 a.m. documented bruise noted to right shin, area appears dark purple/green in color. RN Supervisor notified. Resident remains monitored for changes in condition, will continue to monitor closely and notify RN Supervisor of any further changes. Review of progress notes from 5/18/26, at 12:14 p.m. documented It was reported to writer from CNA that resident refused care d/t (due to) right leg pain. Upon assessment, Right leg is noted to be bruised and swollen, painful to touch, Supervisor aware, phoned ADON (assistant director of nursing), Vitals taken. Review of progress notes from 5/18/26, at 12:40 p.m. documented Spoke at length to grandson regarding the bruising noted to both lower extremities and the swelling noted to the right leg. Unable to perform any type of ROM (range of motion) check at this time as resident yells out and swings at this nurse. Skin temperature is consistent from upper leg to lower leg including foot. Call placed to doctor; he ordered x-rays at this time. Grandson aware and in agreement with x-ray of right hip, femur and tibia/fibula. He would like to be called with results when available. Doctor also ordered new pain meds. Review of an X-Ray report from 5/18/26, at 8:52 p.m. revealed there is an acute mildly displaced spiral fracture below the level of the tibial prosthetic stem. There is evidence of total knee replacement with intact femoral and tibial components in anatomic alignment. There is no radiographic evidence of loosening or particle disease. The bony mineralization is moderately decreased. There is no joint effusion. Review of progress notes from 5/19/26, at 11:44 a.m. documented Spoke with M.D. after he spoke with grandson, grandson agreed to hospice and chose a provider for possible splinting and pain control. Bed rest for 1 week due to pathological fx (fracture). right tibia, Hoyer transfers for future transfers. Review of Workplace Investigation-Employee/Witness Statement Form dated 5/19/26, indicated that Nursing Aide (NA) Employee E1 neglected to follow facility recommended safety measures, and was terminated from her employment. Review of multiple Workplace Investigation-Employee/Witness Statement Form signed and dated from 5/18/26, through 5/19/26 revealed other employees that had seen bruising on bilateral legs after 5/15/26. Review of facility submitted information dated 5/20/26, indicated Resident R86 presented with bruising and swelling to right lower extremity on 5/18/26, at 12:40 p.m. This deficiency is cited as past non-compliance.On 5/18/2026, at 1:00 p.m. the facility initiated a plan of correction that included: -The resident involved was immediately assessed when change in condition was noted on 5/18/2026, at 12:40 p.m., appropriate medical evaluation and monitoring were conducted, portable x-ray ordered and obtained, resident did not leave the facility. -The involved agency staff member was placed on the Do Not Return list at all four [NAME] facilities. -The incident was immediately investigated by the Director of Nursing and the Nursing Home Administrator. -An in-service education program was conducted by the Staff Development Coordinator with all direct care and ancillary staff addressing the facility policies and procedures regarding alleged violations, injuries of unknown origin, and the CMS abuse critical element pathway. Nursing-All residents were audited for any type of abuse at the time of the investigation with audit completed on 5/20/2026, at 1:00 p.m., the Director of Nursing confirmed via verbal report to the Nursing Home Administrator. -All staff were re-educated on policies and procedures regarding alleged violations, injuries of unknown origin, and the CMS Abuse Critical Element Pathway. -Education signature sheets were reviewed with staff signatures for 119 of the facility's total 126 employees by 5/28/26. -Weekly observation audits conducted to observe compliance with wheelchair transport safety. Results on file with the Nursing Home Administrator reviewed and intact. -The Director of Nursing or designee will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks. These residents will be assessed and interviewed to ensure that any alleged violations are identified, properly investigated and reported according to facility policy and procedures. -Resident Interview and Observation Audits communicated and provided to QAPI (Quality Assurance and Performance Improvement) Committee. The facility was back in compliance on 5/28/26. During an (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	interview on 7/7/26, at 11:10 a.m., NA Employee E2 confirmed that training was provided regarding facility policies and procedures regarding alleged violations, injuries of unknown origin, and the CMS abuse critical element pathway. During an interview on 7/7/26, at 11:10 a.m., NA Employee E3 confirmed that training was provided regarding facility policies and procedures regarding alleged violations, injuries of unknown origin, and the CMS abuse critical element pathway. NA Employee E3 also discussed that they received training on transferring residents at the same time. During an interview on 7/7/26, at 11:10 a.m., NA Employee E4 confirmed that training was provided regarding facility policies and procedures regarding alleged violations, injuries of unknown origin, and the CMS abuse critical element pathway. During an interview on 7/7/26, at 11:10 a.m., NA Employee E5 confirmed that training was provided regarding facility policies and procedures regarding alleged violations, injuries of unknown origin, and the CMS abuse critical element pathway. NA Employee E5 also discussed that they received training on transferring and wheelchairs, due to the incident. During an interview on 7/7/26, at 11:10 a.m., Licensed Practical Nurse (LPN) Employee E6 confirmed that training was provided regarding facility policies and procedures regarding alleged violations, injuries of unknown origin, and the CMS abuse critical element pathway. During an interview on 7/7/26, at 11:10 a.m., Licensed Practical Nurse (LPN) Employee E7 confirmed that training was provided regarding facility policies and procedures regarding alleged violations, injuries of unknown origin, and the CMS abuse critical element pathway. Interviews with six of six facility staff present on 7/7/26, indicated they received education on policies and procedures regarding alleged violations, injuries of unknown origin, and the CMS Abuse Critical Element Pathway. During an interview on 7/8/26, at 8:45 a.m. the Nursing Home Administrator confirmed the facility failed to protect residents from abuse for one of four residents that resulted in actual harm of a fracture of the right tibia, which was identified by the surveyor as past non-compliance for Resident R86. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b) (1)(3) Management.28 Pa. Code 211.10(d) Resident Care policies.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on staff interviews it was determined that the facility failed to employ a qualified Food Service Director to manage the daily operations of the Dietary Department for 12 of 12 months (June 2025 through July 2026). Findings include:During an interview on 7/6/26, at approximately 9:46 a.m., the Dietary Supervisor Employee E12 stated that he was the manager and was not certified.During an interview on 7/6/26, at 9:50 a.m., Registered Dietician Employee E13 stated that she works 4 days a week and is clinical only does not manage the dietary department.During an interview on 7/6/26, at approximately 9:50 a.m., the Nursing Home Administrator confirmed that the facility currently does not have a Certified Dietary Manager failed to provide documented evidence that any staff met the qualifications for the position of Food Service Director.Pa Code: 201.18(e)(6) Management.Pa Code: 211.6(c)(d) Dietary 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. Based on observations, and staff interviews, it was determined that the facility failed to maintain sanitary conditions to prevent the potential for cross-contamination or foodborne illness in the main kitchen (Main Kitchen). Findings include:During an observation of the kitchen on 7/6/26, from 9:32 a.m., through 9:46 a.m., the following was observed:The deep freezer had food stored under pipes to fans with ice buildup attached to boxes of food items and dripping into food items underneath. A ham loaf and two other meat packages were not sealed and exposed.The dry storage area had drawers of cereals that were unsealed and could allow for rodents.A can of foam cleanser was on a food prep table with food items. Next to this was a table with multiple rotten/black bananas.The toaster area had a pan of melted butter left uncovered and allowed for potential cross contamination.A cart had a bag of buns on the bottom touching the floor.Dietary Supervisor Employee E12 entered the kitchen with no hair restraint or beard guard.During an interview on 7/6/26, at approximately 9:45 a.m., Dietary Supervisor Employee E12 confirmed that the facility failed to maintain sanitary conditions to prevent the potential for cross-contamination or foodborne illness in the main kitchen (Main Kitchen). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.6(b)(c)(d) Dietary services.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and staff interview it was determined that the facility failed to properly contain and dispose of garbage in one of one outside dumpster to prevent the potential for rodent and insect infestation. Findings include:During an observation and interview of the facility's outdoor trash receptacle on 7/6/26, at approximately 9:46 a.m., with the Nursing Home Administrator, confirmed that there is no lid/cover for the facility dumpster, and it was overflowing with garbage and that the facility failed to properly contain and dispose of garbage in the outside trash receptacle to prevent the potential for rodent and insect infestation.28 Pa. Code 201.18(b)(3) Management.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and staff interviews it was determined that the facility failed to provide a dignified dining experience for two of four residents (Resident R16 and R118). Findings include: Review of the facility policy Feeding Program, dated 6/13/26, with a previous review dare of 6/30/25, indicated that residents are fed in a therapeutic and dignified manner. During an observation on 7/6/26, at approximately 11:45 a.m., Resident R16 was seated at a table with two other residents, one resident was being assisted with her meal by Nurse Aide Employee E8 and the other fed herself. Resident R16 was not fed until the other resident was done at approximately 12:05 p.m. During an observation on 7/6/26, at approximately 11:45 a.m., Resident R118 had received his tray and staff continued to pass trays in dining room. Resident was at a table with another resident who fed himself. Resident R118 was not assisted with his meal until 12:05 p.m., after another resident at another table was finished being assisted by Registered Nurse Employee E9. During an interview on 7/6/26, at 12:05 p.m., Nurse Aide Employee E8 stated that there are only two staff in room and have four feeds. Confirmed that the facility failed to provide a dignified dining experience for Residents R16 and R118. 28 Pa. Code 211.10(a)(c)(d) Resident care policies.28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, review of facility provided documents and staff interview, it was determined that the facility failed to conduct a thorough investigation to rule out the potential for abuse/neglect for one of four residents (Resident R197).Findings include:Review of the facility policy, Abuse-Resident and Reasonable Suspicion of a Crime dated 6/13/26, and previously reviewed 6/30/25, indicated [NAME] Community Living Centers are 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 programs. This policy also provides direction to staff regarding procedures required to protect residents from abuse, to respond appropriately to allegations, to satisfy reporting and notifications obligations, and to conduct investigations. For purpose of this policy staff include facility employees, practitioners, consultants, contractors, volunteers, and students who provide care and services to residents in the facility.Review of the facility policy, Accident Prevention dated 6/13/26, and previously dated 6/30/25, indicated [NAME] Community Living Centers will prevent accidents and injuries to the extent possible by maintaining as much as possible, an environment free from accident hazards and by assuring residents receive adequate supervision and assistive devices to prevent accidents. To safeguard all residents and employees, the facility reserves the right to discharge any residents who willfully and/or repeatedly disregards facility rules and places his/herself and others in danger.Review of the facility policy Incident Report, dated 6/13/26, with a previous review date of 6/30/26, indicated [NAME] Community Living Centers will report and investigate any unusual incidents involving residents. Review of the clinical record indicated Resident R197 was admitted to the facility on [DATE], with diagnoses which included a stroke, contractures, cognitive communication deficit and non-healing pressure ulcers of buttocks and coccyx. Resident R118 had a condom catheter in place to decrease moisture to assist in prevention of worsening coccyx/buttocks wound healing. During a review of an incident dated 6/2/26, at 6:04 a.m., Resident R197 had a 7cm laceration of his penis from the condom catheter. The condom catheter was discontinued and an order for a treatment was applied. Review of the clinical record indicated that on 5/31/26 at approximately 10:10 p.m., that the Nurse Aide caring for Resident R197 had identified that his urine output was low and that the condom catheter became dislodged during the assessment. The Nurse Supervisor had the LPN reapply a new condom catheter at approximately 1:44 a.m., according to documentation. Review of the facility provided documentation of the incident did not include a full investigation or statements from staff in an attempt to identify the root cause of the laceration to rule out the potential for abuse/neglect. During an interview on 7/6/26, at approximately 1:26 p.m., the Nursing Home Administrator confirmed that the facility failed to complete a thorough investigation to rule out the potential for abuse/neglect for Resident R197. 28 Pa Code: 201.29 (a)(c) Resident Rights.28 Pa Code: 211.12 (c)(d)(1)(3)(5) Nursing services.

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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** Based on review of facility policy and clinical records it was determined that the facility failed to notify the physician of increased and decreased Capillary Blood Glucose (CBG) levels and failed to assess residents for hyperglycemia (high blood glucose) and hypoglycemia (low blood glucose) and for change in physical assessment for three of 14 residents (Resident R 3, R11, R137).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 Emergency Care Guidelines: Hypoglycemia Protocol reviewed 6/13/26, and previously reviewed 6/30/25, indicated the facility will provide for timely initiation of emergency treatment for an acute hypoglycemic episode utilizing specific protocols approved by the Medical Director. The facility does not currently have a policy for Hyperglycemia and refers to the orders that the medical director orders for parameters. Review of the facility policy All Policy and Procedure General Guidelines reviewed 6/13/26, and previously reviewed 6/30/25, indicated staff will document all care and services provided to the resident. Documentation should: Be accurate, timely, and reflect the resident's status and condition. Include the rationale for decisions made, including risks and benefits. Include Resident's participation in decisions and tolerance to procedures. Include identification, evaluation, intervention, and attempts made to implement and revise the plan of care to address the changing needs of the resident. Include notification of Resident Representative, Practitioner, Nursing Management, and/or appropriate parties. Only to be completed on facility approved forms. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's Minimum Data Set (MDS-a periodic assessment of care needs) dated 4/9/26, included diagnoses of high blood pressure, diabetes (chronic condition where the body cannot properly process blood glucose), cerebro- vascular accident (occurs when blood flow to a part of the brain is interrupted or reduced, depriving brain tissue of oxygen and nutrients), dementia (decline in cognitive abilities-such as memory, thinking, and reasoning-that is severe enough to interfere with daily life). Review of the physician's orders dated 5/3/26, indicated to inject Lantus (long acting insulin-controls blood glucose for 24 hours without peaking) 30 units at bedtime. Other insulin orders dated 3/20/26 for Novolog (fast-acting insulin tht starts to work about 1 to 2 hours after injection and keeps working for up to 22 hours) inject 6 units with meals, Novolog Sliding scale is extra insulin given depending on glucose readings. Review of the clinical record Electronic Administration Record (eMAR) revealed that the residents' CBG's were as follows:1/3/26: 707/1/26: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	67 Review of Resident R3'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, 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 R137 was admitted to the facility on [DATE]. Review of Resident R137's Minimum Data Set (MDS-a periodic assessment of care needs) dated 6/19/26, included diagnoses of high blood pressure, diabetes, muscle weakness, and cognitive communication deficit (impairment in communication caused by disrupted brain functions like attention, memory, and executive functioning, rather than a primary speech or language disorder). Review of the physician's orders dated 7/12/25, indicated check blood sugars as needed for S/S of hypo or hyperglycemia, if over 350, cover per order, recheck in 4 hours, if still 350 call MD. On 2/23/26, order indicates to obtain post-prandial blood sugar. On 7/12/25, order indicates to obtain fasting blood sugar every A.M. Orders dated 2/23/26 indicate to give Novolog 25 units with breakfast and lunch, also Novolog is to be used as a sliding scale for extra coverage. Review of the clinical record eMAR revealed that the residents' CBG's were as follows:1/1/26: LOW3/26/26: 4324/3/26: 4526/27/26: 0 Review of Resident R137'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, 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 R11 was admitted to the facility on [DATE]. Review of Resident R11's MDS dated [DATE], included diagnoses of high blood pressure, Alzheimer's disease (slowly destroys memory and thinking skills by abnormally building up plaque in the brain which then kills off nerve cells), seizure disorder (sudden abnormal electrical activity in the brain, leading to symptoms ranging from twitches to loss of consciousness), muscle weakness. Review of the clinical record revealed on 6/1/26, it was documented that nursing support staff was notified of a bruise to left eye, the doctor was also notified. No documentation as to how the resident received the bruise was made. On 6/2/26, documentation was made to continue to monitor the bruise to left brow, point of origin unknown. On 6/3/26, at 12:32 a.m. documentation states that the resident does not have a L eye bruise present. On 6/3/25, at 2:36 p.m. documentation states to continue to be monitored r/t bruise to left brow point of origin unknown. The bruise continues to be mentioned until 6/5/26, and then no further mention of the bruise occurs or if it has resolved. During an interview on 7/7/26, at 8:45 a.m. the Nursing Home Administrator confirmed the facility failed to notify the doctor of a change in condition related to blood glucose for Residents R3 and R137 and failed to document accurately for Resident R11. 28 Pa. Code 201.18 (b)(1) Management.28 Pa. Code 201.29(d) Resident Rights.28 Pa. Code 211.1(c)(d) Resident Care policies.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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	07/09/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical records, and staff interview it was determined that the facility failed to make certain that appropriate treatments and services were provided for the use of a condom urinary catheter (a condom placed over the penis to drain urine) for one of four residents using catheters (Resident R197).Findings include: Review of the facility Catheters Care and Drainage dated 6/3/26, with a previous review date of 6/30/25, indicated the purpose of this procedure is to provide staff with instructions to safely and appropriately provide hygiene, monitor output and minimize the growth and transmission of pathogens for residents with urinary catheters. Nursing provides bathing/hygiene per resident care standards. Male residents' genitalia are cleansed, and foreskin is retracted and meatus is wiped rinsed pat dry and replaces foreskin. Staff are to document all care and services provided for residents.Review of the admission record indicated Resident R197 was admitted on [DATE], with diagnoses which included a stroke, contractures, cognitive communication deficit, kidney disease, chronic sacral ulcers. A condom catheter was placed on 2/6/26, to attempt to assist in healing sacral ulcer due to bladder incontinence.Review of Resident R197's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/5/26, indicated the diagnoses remained current.Review of Resident R197's current physician orders did not include identification of use of the condom catheter or care that needed provided.Review of Resident R1's current care plan indicated to check for patency, urinary output and skin for breakdown through review date.Review of an incident report dated 6/2/26, identified Resident R197 had developed a laceration of his penis measuring 7 cm when the condom catheter became dislodged.Review of the clinical documentation did not include care, checking skin, changing catheter, etc. from 3/28/26, through 5/31/26, when the condom catheter became dislodged. During an interview on 7/6/26, at 1:26 p.m., the Nursing [NAME] Administrator confirmed that documentation did not include catheter care, changing of catheter or skin assessments being completed from 3/28/26, through 5/31/26. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(c)(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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	07/09/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident observation and staff interview it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of three residents (Resident R239).Findings include: During an observation on 7/7/26, from 6:54 a.m., through 7:02 a.m., there was Licensed Practical Nurse (LPN) Employee E10 and the 2A clerk on the nursing unit observed. Resident room [ROOM NUMBER]-bathroom call light was illuminating (Resident R239's room). During an observation on 7/7/26, at 7:03 a.m., Resident R239 had ambulated from the bathroom to bed by herself and stated she got tired of waiting for help. When LPN Employee E10 went to assist her as there were no other staff on the unit. Review of Resident R239's plan of care identified that she required assistance of two staff for ambulation and toileting. During a review of 11p-7a staff out punches identified: one NA punched out at 6:48one NA punched out at 6:58 a.m.two others punched out with supervisor at 7amthe first NA for 7-3 shift was observed on the unit at 7:02 a.m. During an interview on 7/7/26, at approximately 7:10 a.m., Nursing Supervisor Employee E11 stated the second nurse for the 2A unit was on 2B charting and no other staff were on unit. During an interview on 7/7/26, at approximately 11:00 a.m., the Nursing Home Administrator confirmed that that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of three residents (Resident R239). Staff should remain on nursing unit until their relief is present. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(e)(6) Management. 28 Pa. Code: 201.20(a) Staff development.28 Pa. Code: 211.12(a)(c)(d)(1)(2)(3)(4) Nursing services.