STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395013	A. Building B. Wing	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eldercrest Healthcare and Rehabilitation Center	2600 West Run Road Munhall, PA 15120

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785 Based on a review of clinical records and resident and staff interview it was determined that the facility failed to involve the resident in the development of the discharge plan for two out of five closed resident records (Closed Resident Record CR1 and CR4). Findings include: The facility Preparing a resident for transfer or discharge policy last reviewed 12/15/23, indicated that residents will be prepared in advance for discharge. A post-discharge plan is developed for each resident prior to his or her transfer or discharge. This plan will be reviewed with the resident. The facility Discharge summary and plan last reviewed 12/15/23, indicated that the resident or resident representative will be involved in the post-discharge planning process and informed of the final discharge plan. Review of Closed Resident Record CR1's admission record indicated he was originally admitted on [DATE], with diagnoses that included diabetes (a metabolic disorder impacting organ function related to glucose levels in the human body), gastrointestinal hemorrhage (bleeding in the intestinal tract that may be life threatening), hypertension (a condition impacting blood circulation through the heart related to poor pressure) and hypothyroidism (decrease in production of thyroid hormone). Review of Closed Resident Record CR1's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 2/19/24, indicated these diagnoses were the most recent upon review. Review of Closed Resident Record CR1's care plan dated 2/26/24, indicated to discharge to the most appropriate level of care, evaluate potential for discharge. Review of Closed Resident Record CR1's physician orders dated 2/29/24, indicated to discharge Closed Resident Record CR1 to personal care with hospital bed and wheelchair. Review of Closed Resident Record CR1's clinical record indicated on 3/4/24, he was discharged to personal care with his belongings. Closed Resident Record CR1 signed his discharge summary on 3/4/24 along with his disposition of property. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395013	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER Eldercrest Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 West Run Road Munhall, PA 15120	

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Closed Resident Record CR1's clinical record did not indicate a review of the discharge plan with Closed Resident Record CR1 prior to discharge and did not include documentation of Closed Resident Record CR1's approval and input about his discharge plan. Review of Closed Resident Record CR4's admission record indicated she was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included hyperlipidemia (elevated lipid levels within the blood), diabetes, and chronic kidney disease (a loss of kidney function resulting in the swelling of feet, fatigue, high blood pressure and changes in urination). Review of Closed Resident Record CR4's MDS assessment dated [DATE], indicated that these were the most recent diagnoses upon review. Review of Closed Resident Record CR4's care plan dated 1/4/24, indicated to discharge to the most appropriate level of care. Review of Closed Resident Record CR4's physician orders dated 1/15/24, indicated to discharge home with occupational therapy, physical therapy, and nursing services. Review of Closed Resident Record CR4's clinical progress note dated 1/15/24, indicated that discharge instructions reviewed with Closed Resident Record CR4, all medications and belongings signed for and taken upon discharge, and she left for home with her daughter. Review of Closed Resident Record CR4's clinical record did not indicate a review of the discharge plan with Closed Resident Record CR4 prior to discharge and did not include documentation of Closed Resident Record CR4's approval and input about her discharge plan. During an interview on 3/23/24, at 1:22 p.m. the Director Social Services Employee E1 confirmed that that the facility failed to involve the resident in the development of the discharge plan and document the approval of a discharge plan with Closed Resident Records CR1 and CR4 as required. During an interview on 3/25/24, at 11:02 a.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to involve the resident in the development of the discharge plan and document the approval of a discharge plan with Closed Resident Records CR1 and CR4 as required. 28 Pa. Code 211.11 (d)(e) Resident care plan. 28 Pa. Code 211.16 (a)(b) Social services.

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Eldercrest Healthcare and Rehabilitation Center	2600 West Run Road Munhall, PA 15120

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785 Based on clinical record review and staff interview, it was determined that the facility failed to provide medically related social services and complete psycho-social based assessments upon admission for four out of five closed resident records (Closed Resident Record CR1, CR2, CR3 and Closed Resident Record CR4). Findings include: The facility Social services coordinator job description last reviewed 12/15/23, indicated that the social services coordinator requires professional knowledge and skills necessary to plan, organize and develop support services. Assist with admissions sign ins, assist discharge residents and families, and assess each resident within seven days of admission. Review of Closed Resident Record CR1's admission record indicated he was originally admitted on [DATE], with diagnoses that included diabetes (a metabolic disorder impacting organ function related to glucose levels in the human body), gastrointestinal hemorrhage (bleeding in the intestinal tract that may be life threatening), hypertension (a condition impacting blood circulation through the heart related to poor pressure) and hypothyroidism (decrease in production of thyroid hormone). Review of Closed Resident Record CR1's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 2/19/24, indicated these diagnoses were the most recent upon review. Review of Closed Resident Record CR1's clinical admission assessment dated [DATE], indicated that he was admitted oriented to person, place, and time. No noted behaviors present. Hearing noted to be adequate. Review of Closed Resident Record CR1's clinical progress notes and admission assessments did not include a psycho-social assessment upon admission to the facility. Review of Closed Resident Record CR2's admission record indicated she was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included a pelvis fracture, hypothyroidism, anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry) and hypertension. Review of Closed Resident Record CR2's MDS assessment dated [DATE], indicated these diagnoses were the most recent upon review. Review of Closed Resident Record CR2's clinical admission assessment dated [DATE], indicated that she was admitted oriented to person, place, and time. No noted behaviors present. She utilized a walker for ambulation. Review of Closed Resident Record CR2's clinical progress notes and admission assessments did not include a psycho-social assessment upon admission to the facility. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Closed Resident Record CR3's admission record indicated she was originally admitted on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), diabetes, and vascular dementia (a condition characterized by memory loss and progressive or persistent loss of intellectual functioning). Review of Closed Resident Record CR3's MDS assessment dated [DATE], indicated these diagnoses were the most recent upon review. Review of Closed Resident Record CR3's Certified Registered Nurse Practitioner (CRNP) admission note dated 2/29/24, indicated she was admitted with general weakness and gait dysfunction. She was living with her mother prior to admission. Review of Closed Resident Record CR3's clinical progress notes and admission assessments did not include a psycho-social assessment upon admission to the facility. Review of Closed Resident Record CR4's admission record indicated she was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included hyperlipidemia (elevated lipid levels within the blood), diabetes, and chronic kidney disease (a loss of kidney function resulting in the swelling of feet, fatigue, high blood pressure and changes in urination). Review of Closed Resident Record CR4's MDS assessment dated [DATE], indicated that these were the most recent diagnoses upon review. Review of Closed Resident Record CR4's clinical admission assessment dated [DATE], indicated she was admitted and was alert, oriented to person, and able to make needs known to staff. Review of Closed Resident Record CR4's clinical progress notes and admission assessments did not include a psycho-social assessment upon admission to the facility. During an interview on 3/23/24, at 11:41 a.m. the Director Social Services Employee E1 confirmed that the facility failed to provide medically related social services and complete psycho-social based assessments upon admission for Closed Resident Record CR1, CR2, and Closed Resident Record CR3 as required During an interview on 3/25/24, at 11:20 a.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to provide medically related social services and complete psycho-social based assessments upon admission for Closed Resident Record CR4 as required. 28 Pa. Code 211.16 (a) Social Services 28 Pa. Code 211.5 (h) Clinical records