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	09/03/2024

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on a review of facility policy, clinical records, incident investigations, and staff interviews, it was determined that the facility failed to ensure that residents are free from misappropriation of property for four of nine residents (Resident R1, R2, R3, and R4). Findings include: Review of the facility policy Abuse, Neglect, & Misappropriation dated 7/31/24, previously reviewed 12/15/23, defined misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Review of the facility policy Identifying Exploitation, Theft and Misappropriation of Resident Property dated 12/15/23, indicated misappropriation of resident property is strictly prohibited, with drug diversion (taking the resident's medication) provided as an example of misappropriation. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2023, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of the clinical record revealed that Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 6/3/24, included diagnoses of chronic kidney disease (gradual loss of kidney function), muscle weakness, and care needed after surgical amputation. Review of Section C revealed Resident R1's BIMS score to be 15. Review of a physician's order dated 5/26/24, indicated Resident R1 received Oxycodone HCL 5 mg (milligrams) tablet (a narcotic pain medication), to give 5 mg mouth every 4 hours as needed for pain moderate 5-7 AND give 10 mg mouth every 4 hours as needed for severe pain 8-10. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R1's Medication Administration Record (MAR) for July 2024, indicated nine administrations of oxycodone: 7/01/24: 5 mg at 8:10 p.m. 7/05/24: 10 mg at 7:02 p.m. 7/06/24: 10 mg at 12:09 p.m. 7/27/24: 5 mg at 2:55 p.m. 7/28/24: 5 mg at 8:09 p.m.; 5 mg at 8:13 p.m. 7/29/24: 5 mg at 12:44 p.m. 7/30/24: 10 mg at 11:59 p.m. 7/31/24: 5 mg at 3:25 p.m. Review of Resident R1's MAR for August 2024, (8/1/24 - 8/15/24) indicated 15 administrations of oxycodone: 8/02/24: 5 mg at 3:38 p.m. 8/04/24: 10 mg at 2:10 a.m. 8/06/24: 5 mg at 9:02 p.m. 8/09/24: 10 mg at 4:28 p.m., 10 mg at 9:09 p.m. 8/10/24: 10 mg at 3:45 p.m., 10 mg at 8:13 p.m. 8/11/24: 10 mg at 4:11 p.m., 10 mg at 8:30 p.m. 8/13/24: 10 mg at 4:22 p.m. 8/14/24: 10 mg at 4:14 p.m., 10 mg at 8:42 p.m. 8/15/24: 10 mg at 12:50 a.m., 10 mg at 4:33 a.m.; 5 mg at 8:26 p.m. The MAR indicated all administrations between 8/10/24, through 8/15/24, at 4:33 a.m. were provided by Licensed Practical Nurse (LPN) Employee E1. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility submitted documentation on 8/16/24, indicated that on 8/15/24, at approximately 0700 (7:00 a.m.), the oncoming nurse was informed via shift change report that the resident had received 10mg of oxycodone at 0430. When the assigned nurse went to pass the routine morning medications to the resident, the nurse inquired about the administration of the PRN oxycodone. Resident informed nurse that he had not received any pain medication at the reported time. The nurse that documented the completed med administration is an agency nurse. Review of a statement written by the Director of Nursing (DON) dated 8/15/24, indicated, At approximately 9:15 this morning, [Registered Nurse (RN) Employee E2] assigned to cart 1 reported to me that there was a suspicious med administration. The med administration involved [Resident R1]. It was reported that [Resident R1] received PRN (as needed) pain meds at 4:30 a.m., but the resident denied receiving them when [RN Employee E2] inquired. Upon learning of this situation, the narcotic medication book was inspected for accuracy. Patterns with the off going nurse, [LPN Employee E1], were apparent. Another resident [Resident R2], also seem to have a questionable med administration documented. I went to talk to [Resident R1], who is alert and oriented. He, again, stated that he had not received any pain medications this morning. I asked him if he received any pain medications throughout the night, he responded no. I asked him if he had received any pain medications last evening, he admitted to taking pain meds sometime around dinner. Between approximately 4pm and 4:30 am, [Resident R1] had four administrations documented by [LPN Employee E1]. After speaking with this resident, I went to speak with [Resident R2], who is also alert and oriented. [Resident R2] told me that she does not want to take narcotics because of a past addiction, but she does take Tylenol (acetaminophen, a non-prescription pain reliever). I asked her when the last time was that she took her oxycodone. She said sometime over the weekend. I asked her specifically if she received the pain medications last night, she responded no. [LPN Employee E1] documented the administration of [Resident R2's] narcotics at approximately 9:00 p.m. last night. Investigation has been launched and [LPN Employee E1] has been removed from the schedule, pending the investigation. Review of a statement provided to the DON, signed by Resident R1, dated 8/15/24, indicated, DON asked [Resident R1] if he received pain medication early this morning. He responded that he did not remember getting pain medication at that time. DON asked when the last time he received pain meds, he responded around dinner time. DON asked if he received pain meds at all throughout the night, he said that he did not and that he slept through the night. During an interview on 8/31/24, at 12:28 p.m. RN Employee E2 stated that on the morning of 8/15/24, LPN Employee E1 had already left the facility when she arrived. RN Employee E2 stated she reviewed the report sheet left by LPN Employee E1 and noted multiple narcotic medication administrations that were not consistent with what was normally provided to the residents. RN Employee E1 stated she asked Resident R1 if he had taken any pain medication overnight, and he stated that he had not. RN Employee E1 stated that at this time she communicated her concerns to nursing administration. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of arthritis (inflammation of one or more joints, causing pain and stiffness), presence of a left artificial knee joint, and care after joint replacement surgery. Review of Section C revealed Resident R2's BIMS score to be 15. Review of a physician's order dated 8/2/24, indicated to give 5 mg mouth every 4 hours as needed for pain moderate 4-6 AND give 10 mg mouth every 4 hours as needed for severe pain 7-10. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R2's MAR for August 2024, (8/1/24 - 8/15/24) indicated 15 administrations of oxycodone: 8/04/24: 10 mg at 10:18 a.m., 10 mg at 4:29 p.m. 8/05/24: 10 mg at 9:26 a.m. 8/06/24: 10 mg at 9:26 a.m. 8/07/24: 10 mg at 9:17 a.m., 10 mg at 4:18 p.m.; 10 mg at 10:32 p.m. 8/08/24: 10 mg at 5:41 a.m., 10 mg at 12:41 p.m. 8/09/24: 10 mg at 10:23 a.m., 10 mg at 10:25 p.m. 8/10/24: 10 mg at 5:46 a.m., 10 mg at 11:17 a.m.; 10 mg at 4:20 p.m.; 10 mg at 9:22 p.m. 8/11/24: 10 mg at 9:06 a.m., 10 mg at 3:50 p.m.; 10 mg at 9:50 p.m. 8/14/24: 10 mg at 8:57 p.m. The MAR indicated that LPN Employee E1 administered the oxycodone on: 8/10/24: 4:20 p.m. and 9:22 p.m. 8/11/24: 3:50 p.m. and 9:50 p.m. 8/14/24: 8:57 p.m. Review of the paper Controlled Drug Record signed by nursing staff when administering the controlled medication, indicated the last dose given of the medication order (36 tablets) was provided on 8/11/24, at 9:50 p.m. by LPN Employee E2. No further medication was available to provide to Resident R2 until the new order was received from the pharmacy, signed as received on 8/14/24. Review of a progress note dated 8/14/24, at 2:10 p.m. indicated, Pain Medication: PRN Tylenol effective per resident. Review of a progress note dated 8/15/24, at 2:53 p.m. indicated, DON asked [Resident R2] if she has been receiving pain medications, as she needs/requests them. Resident responded that she only asks for Tylenol, but she does receive it when requested. DON inquired if Tylenol works, resident responded that Tylenol takes the edge off and makes it bearable. DON explained to the resident that she has the option of taking her prescribed narcotics. Resident declined the invitation to take narcotics, stating that she was afraid of becoming addicted since she had a prior addiction sometime in the past. DON inquired if the resident had taken the narcotics the night prior, resident responded No. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a progress note dated 8/19/24, at 11:20 a.m. indicated, resident being reviewed for recent medication concerns. Resident is currently functioning at psychological baseline. Resident still insists on only taking Tylenol for pain, even after being educated about other available alternatives. Resident's care plan has been updated to reflect possible mood changes in connection with medication concerns. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE], and discharged on [DATE]. Review of the MDS dated [DATE], included diagnoses of spinal stenosis (a narrowing of the spaces within the spine, which causes pain and weakness) and care after an orthopedic procedure. Review of Section C revealed Resident R3's BIMS score to be 15. Review of a physician's order dated 8/7/24, indicated to give 5 mg mouth every 4 hours as needed for moderate pain. Review of a physician's order dated 8/7/24, indicated to give 10 mg mouth every 4 hours as needed for severe pain. Review of Resident R3's MAR for August 2024, (8/7/24 - 8/22/24) indicated one administration of oxycodone (10 mg) on 8/10/24, at 9:05 p.m., provided by LPN Employee E1. During a follow-up interview on 9/1/24, at 2:02 p.m. RN Employee E2 confirmed that she had been Resident R3's nurse from day one and he had never endorsed significant pain. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses hip/femur fracture and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Section C revealed Resident R3's BIMS score to be 4. Review of a physician's order dated 7/25/24, discontinued 8/10/24, indicated to give 5 mg mouth every 6 hours as needed for severe pain. Review of a physician's order dated 8/10/24, indicated to give 5 mg mouth every 6 hours as needed for moderate pain 4-6 AND give 10 mg every 6 hours as needed for severe pain 7-10. Review of Resident R4's MAR for August 2024, (8/1/24 - 8/15/24) indicated: 8/02/24: 5 mg at 3:58 a.m. 8/03/24: 5 mg at 2:15 a.m., 5 mg at 11:41 a.m. 8/05/24: 5 mg at 4:21 a.m. 8/07/24: 5 mg at 8:29 a.m. 8/08/24: 5 mg at 7:26 a.m., 5 mg at 6:39 p.m. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/09/24: 5 mg at 4:20 p.m. 8/10/24: 5 mg at 8:38 a.m.; 10 mg at 3:40 p.m.; 10 mg at 9:47 p.m. 8/11/24: 10 mg at 3:55 p.m.; 10 mg at 9:40 p.m. 8/12/24: 10 mg at 4:23 a.m. 8/13/24: 10 mg at 8:06 p.m. 8/14/24: 10 mg at 8:00 p.m. 8/15/24: 10 mg at 5:46 a.m. The MAR indicated that LPN Employee E1 administered the oxycodone on: 8/10/24: 3:40 p.m. and 9:47 p.m. 8/11/24: 3:55 p.m. and 9:40 p.m. 8/12/24: 4:23 a.m. 8/13/24: 8:06 p.m. 8/14/24: 8:00 p.m. 8/15/24: 5:46 a.m. Review of Resident R4's MAR for August 2024, revealed only one additional administrations of oxycodone on 8/21/24, at 12:26 p.m. (5 mg). Review of the paper Controlled Drug Record indicated additional doses of oxycodone signed out on paper, and not documented in the electronic medical record MAR: 8/22/24: 10 mg at 5:12 p.m. 8/23/24: 10 mg at 9:13 a.m. 8/24/24: 10 mg at 12:12 p.m. During an interview on 8/31/24, at 12:28 p.m. RN Employee E2 stated that on the morning of 8/15/24, she thought the administration of oxycodone to Resident R4 was unusual. RN Employee E2 stated that previously Resident R4 had told therapy staff she did not want to take oxycodone any longer, and that Resident R2 had told her (RN Employee E2) that she did not want pain medication because it made her loopy. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview on 9/1/24, at 2:02 p.m. RN Employee E2 confirmed that Resident R4 is not always able to verbalize her pain due to dementia, but she yells out, Oh shit, oh shit when she is in pain, and that Resident R4 had not been doing that often. During an interview on 9/3/24, at approximately 11:30 a.m. the Director of Nursing confirmed that the facility failed to ensure that residents are free from misappropriation of property for four of nine residents (Resident R1, R2, R3, and R4). 28 Pa. Code: 211.12 (d)(1)(5) Nursing services. 28 Pa. Code: 201.29(j) Resident rights.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on review of facility policy, clinical records, incident reports, resident and staff interview it was determined that failed to report a misappropriation of resident property for one of two residents (Resident R2). Findings include: Review of the facility policy Abuse, Neglect, & Misappropriation dated 7/31/24, previously reviewed 12/15/23, indicated, When staff suspect a crime has occurred against a resident at a facility, they must report the incident to the State Survey Agency and local law enforcement. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2023, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of the clinical record revealed that Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 6/3/24, included diagnoses of chronic kidney disease (gradual loss of kidney function), muscle weakness, and care needed after surgical amputation. Review of Section C revealed Resident R1's BIMS score to be 15. Review of a physician's order dated 5/26/24, indicated Resident R1 received Oxycodone HCL 5 mg (milligrams) tablet (a narcotic pain medication), to give 5 mg mouth every 4 hours as needed for pain moderate 5-7 AND give 10 mg mouth every 4 hours as needed for severe pain 8-10. Review of Resident R1's Medication Administration Record (MAR) for July 2024, indicated nine administrations of oxycodone: 7/01/24: 5 mg at 8:10 p.m. 7/05/24: 10 mg at 7:02 p.m. 7/06/24: 10 mg at 12:09 p.m. 7/27/24: 5 mg at 2:55 p.m. 7/28/24: 5 mg at 8:09 p.m.; 5 mg at 8:13 p.m. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/29/24: 5 mg at 12:44 p.m. 7/30/24: 10 mg at 11:59 p.m. 7/31/24: 5 mg at 3:25 p.m. Review of Resident R1's MAR for August 2024, (8/1/24 - 8/15/24) indicated 15 administrations of oxycodone: 8/02/24: 5 mg at 3:38 p.m. 8/04/24: 10 mg at 2:10 a.m. 8/06/24: 5 mg at 9:02 p.m. 8/09/24: 10 mg at 4:28 p.m., 10 mg at 9:09 p.m. 8/10/24: 10 mg at 3:45 p.m., 10 mg at 8:13 p.m. 8/11/24: 10 mg at 4:11 p.m., 10 mg at 8:30 p.m. 8/13/24: 10 mg at 4:22 p.m. 8/14/24: 10 mg at 4:14 p.m., 10 mg at 8:42 p.m. 8/15/24: 10 mg at 12:50 a.m., 10 mg at 4:33 a.m.; 5 mg at 8:26 p.m. The MAR indicated all administrations between 8/10/24, through 8/15/24, at 4:33 a.m. were provided by Licensed Practical Nurse (LPN) Employee E1. Review of facility submitted documentation on 8/16/24, indicated that on 8/15/24, at approximately 0700 (7:00 a.m.), the oncoming nurse was informed via shift change report that the resident had received 10mg of oxycodone at 0430. When the assigned nurse went to pass the routine morning medications to the resident, the nurse inquired about the administration of the PRN oxycodone. Resident informed nurse that he had not received any pain medication at the reported time. The nurse that documented the completed med administration is an agency nurse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a statement written by the Director of Nursing (DON) dated 8/15/24, indicated, At approximately 9:15 this morning, [Registered Nurse (RN) Employee E2] assigned to cart 1 reported to me that there was a suspicious med administration. The med administration involved [Resident R1]. It was reported that [Resident R1] received PRN (as needed) pain meds at 4:30 a.m., but the resident denied receiving them when [RN Employee E2] inquired. Upon learning of this situation, the narcotic medication book was inspected for accuracy. Patterns with the off going nurse, [LPN Employee E1], were apparent. Another resident [Resident R2], also seem to have a questionable med administration documented. I went to talk to [Resident R1], who is alert and oriented. He, again, stated that he had not received any pain medications this morning. I asked him if he received any pain medications throughout the night, he responded no. I asked him if he had received any pain medications last evening, he admitted to taking pain meds sometime around dinner. Between approximately 4pm and 4:30 am, [Resident R1] had 4 administrations documented by [LPN Employee E1]. After speaking with this resident, I went to speak with [Resident R2], who is also alert and oriented. [Resident R2] told me that she does not want to take narcotics because of a past addiction, but she does take Tylenol (acetaminophen, a non-prescription pain reliever). I asked her when the last time was that she too her oxycodone. She said sometime over the weekend. I asked her specifically if she received the pain medications last night, she responded no. [LPN Employee E1] documented the administration of [Resident R2's] narcotics at approximately 9:00 p.m. last night. Investigation has been launched and [LPN Employee E1] has been removed from the schedule, pending the investigation. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of arthritis (inflammation of one or more joints, causing pain and stiffness), presence of a left artificial knee joint, and care after joint replacement surgery. Review of Section C revealed Resident R1's BIMS score to be 15. Review of a physician's order dated 8/2/24, indicated to give 5 mg mouth every 4 hours as needed for pain moderate 4-6 AND give 10 mg mouth every 4 hours as needed for severe pain 7-10. Review of Resident R2's MAR for August 2024, (8/1/24 - 8/15/24) indicated 15 administrations of oxycodone: 8/04/24: 10 mg at 10:18 a.m., 10 mg at 4:29 p.m. 8/05/24: 10 mg at 9:26 a.m. 8/06/24: 10 mg at 9:26 a.m. 8/07/24: 10 mg at 9:17 a.m., 10 mg at 4:18 p.m.; 10 mg at 10:32 p.m. 8/08/24: 10 mg at 5:41 a.m., 10 mg at 12:41 p.m. 8/09/24: 10 mg at 10:23 a.m., 10 mg at 10:25 p.m. 8/10/24: 10 mg at 5:46 a.m., 10 mg at 11:17 a.m.; 10 mg at 4:20 p.m.; 10 mg at 9:22 p.m. 8/11/24: 10 mg at 9:06 a.m., 10 mg at 3:50 p.m.; 10 mg at 9:50 p.m. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/14/24: 10 mg at 8:57 p.m. The MAR indicated that LPN Employee E1 administered the oxycodone on: 8/10/24: 4:20 p.m. and 9:22 p.m. 8/11/24: 3:50 p.m. and 9:50 p.m. 8/14/24: 8:57 p.m. Review of the paper Controlled Drug Record signed by nursing staff when administering the controlled medication, indicated the last dose given of the medication order (36 tablets) was provided on 8/11/24, at 9:50 p.m. by LPN Employee E2. No further medication was available to provide to Resident R2 until the new order was received from the pharmacy, signed as received on 8/14/24. Review of a progress note dated 8/14/24, at 2:10 p.m. indicated, Pain Medication: PRN Tylenol effective per resident. Review of a progress note dated 8/15/24, at 2:53 p.m. indicated, DON asked [Resident R2] if she has been receiving pain medications, as she needs/requests them. Resident responded that she only asks for Tylenol, but she does receive it when requested. DON inquired if Tylenol works, resident responded that Tylenol takes the edge off and makes it bearable. DON explained to the resident that she has the option of taking her prescribed narcotics. Resident declined the invitation to take narcotics, stating that she was afraid of becoming addicted since she had a prior addiction sometime in the past. DON inquired if the resident had taken the narcotics the night prior, resident responded No. During an interview on 8/31/24, at approximately 4:55 p.m. the Director of Nursing confirmed that the report submitted to the State Survey Agency communicated one administration of oxycodone, suspect for drug diversion, for one resident, Resident R1. The Director of Nursing confirmed that the facility investigation revealed multiple instances of drug diversion for both Resident R1 and Resident R2. During an interview on 8/31/24, at approximately 4:55 p.m. the Director of Nursing confirmed that failed to report a misappropriation of resident property for one of two residents. 28 Pa. Code: 201.14(a)(c)(e) Responsibility of mangement. 28 Pa. Code: 201.18(b)(1)(e)(1) Management.

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	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **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 implement policies and procedures to investigate misappropriation of resident property for eight of nine residents (Resident R1, R2, R3, R4, R5, R6, R7, and R8) Findings include: Review of the facility policy Abuse, Neglect, & Misappropriation dated 7/31/24, previously reviewed 12/15/23, defined misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Review of the facility policy Controlled Substances Accountability Guide dated 12/29/21, indicated under Chapter 8: Suspected Diversion, indicated In cases where diversion is suspected or the suspicion of diversion needs to be ruled out, the facility should observe frequent PRN (as needed) use that cannot be explained by resident condition, frequent PRN use limited to a specific nurse, and frequent PRN use of narcotic analgesia not supported by pain assessment. Review of the Resident Assessment Instrument 3.0 User's Manual, effective October 2023, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of the clinical record revealed that Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 6/3/24, included diagnoses of chronic kidney disease (gradual loss of kidney function), muscle weakness, and care needed after surgical amputation. Review of Section C revealed Resident R1's BIMS score to be 15. Review of a physician's order dated 5/26/24, indicated Resident R1 received Oxycodone HCL 5 mg (milligrams) tablet (a narcotic pain medication), to give 5 mg mouth every 4 hours as needed for pain moderate 5-7 AND give 10 mg mouth every 4 hours as needed for severe pain 8-10. Review of Resident R1's Medication Administration Record (MAR) for July 2024, indicated nine administrations of oxycodone: 7/01/24: 5 mg at 8:10 p.m. 7/05/24: 10 mg at 7:02 p.m. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/06/24: 10 mg at 12:09 p.m. 7/27/24: 5 mg at 2:55 p.m. 7/28/24: 5 mg at 8:09 p.m.; 5 mg at 8:13 p.m. 7/29/24: 5 mg at 12:44 p.m. 7/30/24: 10 mg at 11:59 p.m. 7/31/24: 5 mg at 3:25 p.m. Review of Resident R1's MAR for August 2024, (8/1/24 - 8/15/24) indicated 15 administrations of oxycodone: 8/02/24: 5 mg at 3:38 p.m. 8/04/24: 10 mg at 2:10 a.m. 8/06/24: 5 mg at 9:02 p.m. 8/09/24: 10 mg at 4:28 p.m., 10 mg at 9:09 p.m. 8/10/24: 10 mg at 3:45 p.m., 10 mg at 8:13 p.m. 8/11/24: 10 mg at 4:11 p.m., 10 mg at 8:30 p.m. 8/13/24: 10 mg at 4:22 p.m. 8/14/24: 10 mg at 4:14 p.m., 10 mg at 8:42 p.m. 8/15/24: 10 mg at 12:50 a.m., 10 mg at 4:33 a.m.; 5 mg at 8:26 p.m. The MAR indicated all administrations between 8/10/24, through 8/15/24, at 4:33 a.m. were provided by Licensed Practical Nurse (LPN) Employee E1. Review of facility submitted documentation on 8/16/24, indicated that on 8/15/24, at approximately 0700 (7:00 a.m.), the oncoming nurse was informed via shift change report that the resident had received 10mg of oxycodone at 0430 (4:30 a.m.). When the assigned nurse went to pass the routine morning medications to the resident, the nurse inquired about the administration of the PRN oxycodone (a narcotic pain medication). Resident informed nurse that he had not received any pain medication at the reported time. The nurse that documented the completed med administration is an agency nurse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a statement written by the Director of Nursing (DON) dated 8/15/24, indicated, At approximately 9:15 this morning, [Registered Nurse (RN) Employee E2] assigned to cart 1 reported to me that there was a suspicious med administration. The med administration involved [Resident R1]. It was reported that [Resident R1] received PRN (as needed) pain meds at 4:30 a.m., but the resident denied receiving them when [RN Employee E2] inquired. Upon learning of this situation, the narcotic medication book was inspected for accuracy. Patterns with the off going nurse, [LPN Employee E1], were apparent. Another resident [Resident R2], also seem to have a questionable med administration documented. I went to talk to [Resident R1], who is alert and oriented. He, again, stated that he had not received any pain medications this morning. I asked him if he received any pain medications throughout the night, he responded no. I asked him if he had received any pain medications last evening, he admitted to taking pain meds sometime around dinner. Between approximately 4pm and 4:30 am, [Resident R1] had 4 administrations documented by [LPN Employee E1]. After speaking with this resident, I went to speak with [Resident R2], who is also alert and oriented. [Resident R2] told me that she does not want to take narcotics because of a past addiction, but she does take Tylenol (acetaminophen, a non-prescription pain reliever). I asked her when the last time was that she too her oxycodone. She said sometime over the weekend. I asked her specifically if she received the pain medications last night, she responded no. [LPN Employee E1] documented the administration of [Resident R2's] narcotics at approximately 9:00 p.m. last night. Investigation has been launched and [LPN Employee E1] has been removed from the schedule, pending the investigation. Review of Resident R1's paper Controlled Drug Record indicated additional doses of oxycodone signed out on paper, and not documented in the electronic medical record MAR: 7/3/24: 5 mg at 8:00 p.m. 7/9/24: 5 mg at 9:00 p.m. 7/19/24: 5 mg at 12:00 p.m. 8/1/24: 5 mg at 5:00 p.m. 8/18/24: 5 mg at 9:00 p.m. 8/20/24: 5 mg at 9:00 p.m. 8/25/24: 5 mg at 8:00 p.m. 8/27/24: 5 mg at 6:37 p.m. Further review of the facility investigation documents and clinical record for Resident R1 failed to reveal that the additional doses of oxycodone provided without documentation were investigated. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of arthritis (inflammation of one or more joints, causing pain and stiffness), presence of a left artificial knee joint, and care after joint replacement surgery. Review of Section C revealed Resident R2's BIMS score to be 15. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a physician's order dated 8/2/24, indicated to give 5 mg mouth every 4 hours as needed for pain moderate 4-6 AND give 10 mg mouth every 4 hours as needed for severe pain 7-10. Review of Resident R2's MAR for August 2024, (8/1/24 - 8/15/24) indicated 15 administrations of oxycodone: 8/04/24: 10 mg at 10:18 a.m., 10 mg at 4:29 p.m. 8/05/24: 10 mg at 9:26 a.m. 8/06/24: 10 mg at 9:26 a.m. 8/07/24: 10 mg at 9:17 a.m., 10 mg at 4:18 p.m.; 10 mg at 10:32 p.m. 8/08/24: 10 mg at 5:41 a.m., 10 mg at 12:41 p.m. 8/09/24: 10 mg at 10:23 a.m., 10 mg at 10:25 p.m. 8/10/24: 10 mg at 5:46 a.m., 10 mg at 11:17 a.m.; 10 mg at 4:20 p.m.; 10 mg at 9:22 p.m. 8/11/24: 10 mg at 9:06 a.m., 10 mg at 3:50 p.m.; 10 mg at 9:50 p.m. 8/14/24: 10 mg at 8:57 p.m. The MAR indicated that LPN Employee E1 administered the oxycodone on: 8/10/24: 4:20 p.m. and 9:22 p.m. 8/11/24: 3:50 p.m. and 9:50 p.m. 8/14/24: 8:57 p.m. Review of the paper Controlled Drug Record signed by nursing staff when administering the controlled medication, indicated the last dose given of the medication order (36 tablets) was provided on 8/11/24, at 9:50 p.m. by LPN Employee E2. No further medication was available to provide to Resident R2 until the new order was received from the pharmacy, signed as received on 8/14/24. Review of a progress note dated 8/14/24, at 2:10 p.m. indicated, Pain Medication: PRN Tylenol effective per resident. Review of a progress note dated 8/15/24, at 2:53 p.m. indicated, DON asked [Resident R2] if she has been receiving pain medications, as she needs/requests them. Resident responded that she only asks for Tylenol, but she does receive it when requested. DON inquired if Tylenol works, resident responded that Tylenol takes the edge off and makes it bearable. DON explained to the resident that she has the option of taking her prescribed narcotics. Resident declined the invitation to take narcotics, stating that she was afraid of becoming addicted since she had a prior addiction sometime in the past. DON inquired if the resident had taken the narcotics the night prior, resident responded No. (continued on next page)

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	395013	A. Building B. Wing	09/03/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a progress note dated 8/19/24, at 11:20 a.m. indicated, resident being reviewed for recent medication concerns. Resident is currently functioning at psychological baseline. Resident still insists on only taking Tylenol for pain, even after being educated about other available alternatives. Resident's care plan has been updated to reflect possible mood changes in connection with medication concerns. Review of the paper Controlled Drug Record indicated additional doses of oxycodone signed out on paper, and not documented in the electronic medical record MAR: 8/16/24: 10 mg at 8:27 a.m. 8/20/24: 10 mg at 12:27 a.m. (time partially illegible) 8/21/24: 10 mg at 10:17 a.m. (time partially illegible) 8/22/24: 10 mg at 12:15 a.m. Further review of the facility investigation documents and clinical record for Resident R2 failed to reveal that the additional doses of oxycodone provided without documentation were investigated. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE], and discharged on [DATE]. Review of the MDS dated [DATE], included diagnoses of spinal stenosis (a narrowing of the spaces within the spine, which causes pain and weakness) and care after an orthopedic procedure. Review of Section C revealed Resident R3's BIMS score to be 15. Review of a physician's order dated 8/7/24, indicated to give oxycodone 5 mg mouth every 4 hours as needed for moderate pain. Review of a physician's order dated 8/7/24, indicated to give oxycodone 10 mg mouth every 4 hours as needed for severe pain. Review of Resident R3's MAR for August 2024, (8/7/24 - 8/22/24) indicated one administration of oxycodone (10 mg) on 8/10/24, at 9:05 p.m., provided by LPN Employee E1. Review of the facility provided investigation revealed a Controlled Drug Record for August 2024, that confirmed LPN Employee E1 provided the only dose of oxycodone to Resident R4. Further review of the facility investigation documents and clinical record for Resident R4 failed to reveal any attempt to interview Resident R4, an alert and oriented resident, to confirm if the medication was received. No documentation was provided that indicated the oxycodone administration by LPN Employee E1 was investigated. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. (continued on next page)

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	395013	A. Building B. Wing	09/03/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS dated [DATE], included diagnoses hip/femur fracture and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Section C revealed Resident R3's BIMS score to be 4. Review of a physician's order dated 7/25/24, discontinued 8/10/24, indicated to give 5 mg mouth every 6 hours as needed for severe pain. Review of a physician's order dated 8/10/24, indicated to give 5 mg mouth every 6 hours as needed for moderate pain 4-6 AND give 10 mg every 6 hours as needed for severe pain 7-10. Review of Resident R4's MAR for August 2024, (8/1/24 - 8/15/24) indicated LPN Employee E1 administered the oxycodone on: 8/10/24: 3:40 p.m. and 9:47 p.m. 8/11/24: 3:55 p.m. and 9:40 p.m. 8/12/24: 4:23 a.m. 8/13/24: 8:06 p.m. 8/14/24: 8:00 p.m. 8/15/24: 5:46 a.m. Review of Resident R4's MAR for August 2024, revealed only one additional administrations of oxycodone on 8/21/24, at 12:26 p.m. (5 mg). Review of the paper Controlled Drug Record indicated additional doses of oxycodone signed out on paper, and not documented in the electronic medical record MAR: 8/07/24: 5 mg at 2:40 p.m. 8/22/24: 10 mg at 5:12 p.m. 8/23/24: 10 mg at 9:13 a.m. 8/24/24: 10 mg at 12:12 p.m. Further review of the facility investigation documents and clinical record for Resident R4 failed to reveal that the oxycodone administrations by LPN Employee E1 were investigated, or that the additional doses of oxycodone provided without documentation were investigated. Review of the clinical record indicated Resident R5 was admitted to the facility on [DATE]. (continued on next page)

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	395013	A. Building B. Wing	09/03/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS dated [DATE], included diagnoses of arthritis (inflammation of one or more joints, causing pain and stiffness) and schizoaffective disorder (a mental disorder in which a person experiences a combination of schizophrenia and mood disorder symptoms). Review of Section B: Hearing, Speech, and Vision indicated Resident R5 is understood and understands. Section C was not assessed on this MDS. Review of the MDS dated [DATE], Review of Section C revealed Resident R5's BIMS score to be 13. Review of a physician's order dated 7/10/24, indicated to give tramadol (a narcotic pain medication) 50 mg mouth, three times per day, as needed for pain. Review of Resident R5's MAR for August 2024, indicated twelve administration of Tramadol 50 mg from 8/1/24, through 8/15/24, three of the twelve provided by LPN Employee E1. No further administrations were documented in the in August 2024 MAR. Review of the paper Controlled Drug Record indicated additional doses of Tramadol signed out on paper, and not documented in the electronic medical record MAR: 7/11/24 at 8:00 p.m. 7/18/24 at 8:30 (no a.m. or p.m. documented) 7/25/24 at 8:35 p.m. 8/06/24 at 10:00 p.m. 8/16/24 at 12:00 p.m. 8/17/24 at 9:00 a.m. 8/18/24 at 9:00 a.m. 8/18/24 at 7:00 p.m. 8/20/24 at 9:00 p.m. 8/25/24 at 9:00 p.m. Further review of the facility investigation documents and clinical record for Resident R5 failed to reveal any attempt to interview Resident R5, an alert and oriented resident, to confirm if the medication was received. No documentation was provided that indicated the Tramadol administrations by LPN Employee E1 were investigated or that the additional doses of Tramadol provided without documentation were investigated. Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE], and discharged on [DATE]. (continued on next page)

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	395013	A. Building B. Wing	09/03/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS dated [DATE], included diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness) and care after joint replacement surgery. Review of Section C revealed Resident R2's BIMS score to be 14. Review of a physician's order dated 8/1/24, indicated to give oxycodone 5 mg by mouth, every six hours, as needed for severe pain. Review of Resident R6's MAR for August 2024, indicated LPN Employee E1 administered oxycodone 10 mg on the following dates and times: 8/10/24 at 3:50 p.m. 8/10/24 at 10:47 p.m. 8/11/24 at 7:58 p.m. 8/12/24 at 2:03 a.m. 8/13/24 at 6:26 p.m. 8/14/24 at 8:10 p.m. 8/15/24 at 1:36 a.m. Further review of the facility investigation documents and clinical record for Resident R6 failed to reveal any attempt to interview Resident R6, an alert and oriented resident, to confirm if the medication was received. No documentation was provided that indicated the oxycodone administrations by LPN Employee E1 were investigated. Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE], and discharged on [DATE]. Review of the MDS dated [DATE], included diagnoses of COPD and care after an orthopedic procedure. Review of Section C revealed Resident R2's BIMS score to be 14. Review of a physician's order dated 7/25/24, indicated to give oxycodone 5 mg by mouth, every six hours, as needed for pain. Review of Resident R7's MAR for August 2024, indicated LPN Employee E1 administered oxycodone 5 mg on the following dates and times: 8/10/24 at 3:33 p.m. 8/10/24 at 9:00 p.m. 8/11/24 at 9:25 p.m. 8/11/24 at 3:55 p.m. (continued on next page)

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	395013	A. Building B. Wing	09/03/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/12/24 at 3:02 a.m. 8/13/24 at 4:30 p.m. 8/14/24 at 3:30 p.m. 8/14/24 at 9:11 p.m. 8/15/24 at 2:27 a.m. Further review of the facility investigation documents and clinical record for Resident R7 failed to reveal any attempt to interview Resident R7, an alert and oriented resident, to confirm if the medication was received. No documentation was provided that indicated the oxycodone administrations by LPN Employee E1 were investigated. Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of chronic kidney disease (gradual loss of kidney function) and gout (a form of arthritis that causes severe pain, swelling, redness and tenderness in joints). Review of Section C revealed Resident R2's BIMS score to be 10. Review of a physician's order dated 5/9/23, indicated to give tramadol 50 mg mouth, every eight hours, as needed for pain. Review of the paper Controlled Drug Record indicated additional doses of Tramadol signed out on paper, and not documented in the electronic medical record MAR: 8/1/24 at (illegible time). 8/3/24 at 8:00 p.m. 8/4/24 at 9:00 a.m. 8/4/24 at 8:00 p.m. 8/6/24 at 9:15 a.m. 8/6/24 at 8:00 p.m. 8/8/24 at 9:11 p.m. 8/11/24 at 8:15 p.m. 8/18/24 at 8:00 p.m. 8/20/24 at 8:00 p.m. 8/21/24 at 8:00 p.m. (continued on next page)

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	395013	A. Building B. Wing	09/03/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/22/24 at (illegible time). 8/23/24 at 8:25 p.m. 8/25/24 at 9:00 p.m. 8/28/24 at 8:54 p.m. 8/31/24 at 8:00 p.m. 9/01/24 at 8:00 p.m. Further review of the facility investigation documents and clinical record for Resident R8 failed to reveal that the additional doses of Tramadol provided without documentation were investigated. During an interview on 9/3/24, at approximately 11:30 a.m. the Director of Nursing confirmed that the facility failed to implement policies and procedures to investigate misappropriation of resident property for eight of nine residents. 28 Pa. Code: 201.18(e)(1)(2) Management. 28 Pa. Code: 201.29(a)(c)(d) Resident rights. 28 PA. Code: 211.12(a)(c)(d)(1)(3)(5) Nursing services.

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	395013	A. Building B. Wing	09/03/2024

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 39311 Based on review of facility policy, resident observations, resident and staff interviews, and grievance review, 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 of five of eight residents (Residents R1, R9, R10, R11, and R12). Findings Include: Review of the facility policy, Activities of Daily Living (ADLs), Supporting dated 7/31/24, previously reviewed 12/15/23, indicated residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. During an interview on 8/31/24, at 2:15 p.m. Resident R12, when asked if she felt the facility maintained sufficient staff, stated, No, and the evening shift doesn't do their jobs. When asked if call lights took a long time to be answered, stated that she has waited 2 - 2 1/2 hours for care to be provided, and further confirmed that she has been left in soiled briefs and clothing. During an interview on 8/31/24, at 2:22 p.m. Resident R9, when asked if she felt the facility maintained sufficient staff, stated, No, they need more help. When you are on the toilet you have to wait like an hour to get off. When asked if call lights took a long time to be answered, stated, A while, it's cause there's just not enough help, that's all. During an interview on 8/31/24, at 2:30 p.m. Resident R10, when asked if she felt the facility maintained sufficient staff, stated, No. When asked if she has ever been left soiled for an extended period of time, stated, Yes, constantly. I get left overnight. I rang the bell before shift change and didn't get changed until 1 p. m. today. I had diarrhea all up in my front parts. I've had diarrhea for four days and I've been left dirty for hours. Resident R10 further stated, If I don't get everything after dinner, you can forget it. Review of Resident R10's bowel record failed to reveal any incontinence care provided between 8/30/24, at 4:33 p.m. and 8/31/24, at 2:59 p.m. During an interview on 8/31/24, at 3;47 p.m. Resident R1, when asked if he felt the facility maintained sufficient staff, stated, No. When asked if call lights took a long time to be answered, stated, They come, and they say they will come back, but they don't. I've waited an hour. Resident R1 further stated that he has been left soiled multiple times, and has had staff members ask him why he cannot take himself to the bathroom. During an interview on 8/31/24, at approximately 4:55 p.m. the Director of Nursing confirmed 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 of five of eight residents. (continued on next page)

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	09/03/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.