

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/14/2025
NAME OF PROVIDER OR SUPPLIER Eldercrest Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 interview, it was determined that the facility failed to properly restrain hair to prevent the potential for cross contamination in the Main Kitchen. Findings include: Review of facility policy Code of Dress and Personal Appearance reviewed 7/31/25, indicated employees will use effective hair restraints, such as hair nets, hair bonnets, and beard guards to prevent contamination of food or food contact surfaces. During an observation on 11/12/25, at 9:55 a.m. Nurse Aide (NA) Employee E3, and Dietary Aide Employee E4 were in the kitchen without hair nets covering their hair, and [NAME] Employee E5 was observed in the kitchen without a beard guard. During an interview on 11/12/25, at 11:03 a.m. Dietary Manager Employee E6 confirmed staff should be wearing hair nets and beard guards while in the kitchen. During an observation on 11/14/25, at 10:45 a.m. [NAME] Employee E5 was in the kitchen without a beard guard. Dietary Manager Employee E6 was observed in the kitchen with a hair net covering only the hair in a bun at the crown of her head, leaving from her forehead to crown exposed and uncovered. During an interview on 11/14/25, at 10:45 a.m. Dietary Manager Employee E6 stated the hair net must have slipped up my round head. During an interview on 11/14/25, at 11:25 a.m. the Nursing Home Administrator confirmed the kitchen staff should wear hair nets to cover all hair and/or mustache/beard restraints, if facial hair is present. 28 Pa. Code: 211.6(c)(d)(f) Dietary services.		

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on review of facility policy and facility documents, resident council meeting and resident and staff interview it was determined that the facility failed to document, investigate, resolve and protect the residents from reprisal during the investigative process when filing/ identifying concerns/grievances for 11 of 18 residents (Residents R1, R2, R3, R4, R700, R701, R702, R703, R704, R705 and R706). Findings include:Review of the facility Grievances Procedure dated 7/31/25, with a previous review date of 7/31/24, indicated the resident has a right to let their concerns be known through the grievance process which first goes through the Grievance officer, identified as the Nursing Home Administrator. The facility is responsible for the review, investigation and resolution of each grievance while protecting the resident from reprisal during the investigative process. Review of the facility grievances dated June 2025 through November 2025, identified two filed grievances that had not been investigated and the three residents identified were not protected from reprisal as per documentation within the grievance from all three individuals. During the Resident Council Meeting held on 11/12/25, at 1:30 p.m., identified the council consensus stating the facility has not protected residents during investigations related to grievances. During an individual interview on 11/13/25, at 8:30 a.m., Resident R6 stated that a concern had been given to the Assistant Director of Nursing Employee E1, and after the concern was provided, Nurse Aide (NA) Employee E2 identified as the staff involved came back to the resident and asked her why did you turn me in which caused the resident to be fearful of reprisal from the NA. During an interview on 11/13/25, at 8:50 a.m., the Director of Nursing confirmed that the facility failed to document, investigate, resolve and protect the residents from reprisal during the investigative process when filing/ identifying concerns/grievances for 11 of 18 residents (Residents R1, R2, R3, R4, R700, R701, R702, R703, R704, R705 and R706).28 Pa. Code 201.14(b) Responsibility of licensee.28 Pa. Code 201.18(b)(1)(e)(1) Management.28 PA Code: 201.29(a) Resident rights.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on review of facility policies, grievances, clinical records, and resident and staff interview, it was determined that the facility failed to ensure that residents were free from potential abuse/neglect for five of six residents reviewed (Residents R31, R50, R41, R29 and R??) Findings include:Review of the facility Identifying Neglect dated 7/31/25, indicated that the facility strategy to prevent abuse, neglect, mistreatment, and exploitation of residents all staff, volunteers and contractors are trained to identify abuse and neglect as it may occur against residents.Review of a submitted grievance dated 8/28/25, indicated Resident R31 granddaughter was visiting and Nurse Aide Employee E3 had been arguing with the Resident's granddaughter in the resident's room then followed the resident's granddaughter outside continuing to argue.Review of the information provided by the Director of Nursing (DON) and subsequent interview on 11/12/25, at 12:10 p.m., did not include that the facility identified the concern as potential for abuse/neglect as the Nurse Aide continued to care for the resident after the altercation occurred and did not indicate any investigation had occurred to make certain the NA did not cause mental anguish for Resident R31 or any other resident/family. Review of a grievance dated 9/10/25, indicated Residents R41 and R50 had indicated that Nurse Aides on the afternoon shifts on the past Sunday (9/7) and Monday (9/8) did not answer call bells and used loud voice.During an interview on 11/12/25, at 12:10 p.m., the DON stated that she did not identify the grievance as potential abuse/neglect and did not investigate the incident or protect the residents from potential continued abuse/neglect as staff were not all identified.During an interview on 11/13/25, at 8:40 a.m., Resident R29 stated that she had gone to the Assistant Director of Nursing about Nurse Aide (NA) Employee E2 and reported her for speaking about another resident in front of her in a concerning manner. Resident R29 stated that she was concerned about retaliation and fearful after NA Employee E2 came into her room and said, why did you report me? to Resident R29. The facility failed to protect Resident R29.During an interview on 11/13/25, at 8:50 a.m., the DON confirmed that the facility failed to protect residents from potential for abuse/ neglect.28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(b)(1)(e)(1) Management.28 Pa. Code 201.29(j) Resident Rights.		

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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** Based on review of facility policy, grievances, facility documents, clinical record reviews and staff interview, it was determined that the facility failed to initiate a thorough investigation for allegations of abuse/neglect for five of six residents (Residents R31, R50, R41, R29 and R??). Findings include: Review of the facility policy Abuse Investigating and Reporting, dated 7/31/25, indicated that all reports of abuse, neglect, exploitation, misappropriation of property, mistreatment and injuries of unknown source will be promptly reported to the Administrator who will assign the investigation to the appropriate individual. The Administrator will immediately suspend the accused pending the outcome of the investigation and will ensure that any further potential abuse, neglect, etc., is prevented. The alleged abuse, neglect, etc., will be reported to the local, state and Federal agencies as defined by current regulations. Review of a submitted grievance dated 8/28/25, indicated Resident R31 granddaughter was visiting and Nurse Aide Employee E3 had been arguing with the Resident's granddaughter in the resident's room then followed the resident's granddaughter outside continuing to argue. Review of the clinical record indicated that Resident R31 was admitted to the facility on [DATE], with diagnoses which included Alzheimer's dementia, and heart failure. A Minimum Data Set (MDS- a periodic assessment of resident care needs) dated 10/11/25, indicated the diagnoses remained current and Resident R31's Brief Interview for Mental (BIM) ability indicated her score 15/15. Review of the information provided by the Director of Nursing (DON) and subsequent interview on 11/12/25, at 12:10 p.m., did not include that the facility identified the concern as potential for abuse/neglect as the Nurse Aide continued to care for the resident after the altercation occurred and did not indicate any investigation and/ or reporting of alleged potential abuse. The facility failed to protect Resident R31 from potential further abuse or mental anguish during the investigation as the NA continued to work. Review of a grievance dated 9/10/25, indicated Residents R41 and R50 had indicated that Nurse Aides on the afternoon shifts on the past Sunday (9/7) and Monday (9/8) did not answer call bells and used loud voice. Review of the clinical record indicated Resident R41 was admitted to the facility on [DATE], with diagnoses which included diabetes, asthma and Lymphoma. An MDS dated [DATE], indicated the diagnoses remained current and Resident R41's BIM score was 15/15. Review of Resident the clinical record indicated that Resident R50 was admitted to the facility on [DATE], with diagnoses which included a stroke and lung disease. An MDS dated [DATE], indicated the diagnoses remained current and that Resident R50's BIM score was 15/15. During an interview on 11/12/25, at 12:10 p.m., the DON stated that she did not identify the grievance as potential abuse/neglect and did not investigate the incident or protect the residents from potential continued abuse/neglect as staff were not all identified. The facility failed to report the allegations as well. During an interview on 11/13/25, at 8:40 a.m., Resident R29 stated that she had gone to the Assistant Director of Nursing about Nurse Aide (NA) Employee E2 and reported her for speaking about another resident in front of her in a concerning manner. Resident R29 stated that she was concerned about retaliation and fearful after NA Employee E2 came into her room and said, why did you report me? to Resident R29. The facility failed to protect Resident 29. During an interview on 11/13/25, at 8:50 a.m., the DON confirmed that the facility failed to identify concerns of alleged abuse/neglect, failed to investigate potential abuse neglect and failed to report allegations of abuse/ neglect for five of six residents (Residents R31, R50, R41, R29 and R??). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10 (c)(d) Resident Care policies. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, observation, and interviews with staff, it was determined that the facility failed to make certain residents were provided necessary treatment and services, consistent with professional standards of practice, for a pressure ulcer (PU/PIs- injuries to skin and underlying tissue resulting from prolonged pressure on the skin) for one of three residents (Resident R35). Review of the facility policy Prevention of Pressure Ulcers, dated 7/31/25, indicated that residents are assessed on admission (within eight hours) for existing pressure ulcer/injury and risk factors. the assessment is repeated weekly and upon any changes in condition. Review of the clinical record indicated that Resident R35 was admitted to the facility on [DATE], with diagnoses which included COVID, diabetes, kidney disease and heart fibrillation. A MDS (Minimum Data Set- a periodic assessment of resident care needs) dated 11/7/25, indicated the diagnoses remained current. Section GG0115 (impairment of extremities) identified bilateral lower extremities are impaired. Section GG0170 (resident's ability to move) identified that Resident R35 required maximum assistance to roll left to right in bed. Review of the clinical record indicated Resident R35 was sent to the hospital on [DATE], due to altered mental status and low blood pressure. She was re-admitted to the facility on [DATE]. Review of Resident R35's readmission skin assessment dated [DATE], did not include an examination of her skin. Review of a progress note dated 11/13/25, indicated that a Nurse Aide had the nurse assess Resident coccyx area which identified a 5 cm x 1 cm open area. At this time a treatment was ordered. During an interview on 11/13/25, at 11:27 a.m., the Director of Nursing confirmed that the facility failed to make certain residents were provided necessary treatment and services, consistent with professional standards of practice, for a pressure ulcer (PU/PIs- injuries to skin and underlying tissue resulting from prolonged pressure on the skin) for one of three residents (Resident R35).		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policy, clinical record review, and a staff interview, it was determined that the facility failed to maintain accurate resident care plans and conduct ongoing accurate assessments to ensure that bedrails/enabler bars were used to meet residents' needs and the risks associated with bedrail usage for three of six residents (Residents R4, R32, and R42). Findings include: Review of facility policy Proper Use of Bed Rails dated 7/31/25, indicated as part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs, and whether or not the use of bed rails meets those needs: diagnosis, size and weight, sleep habits, medications, acute medical interventions, underlying medical conditions, existence of delirium, ability to toilet self, cognition, communication mobility, risk of falling. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/18/25, indicated diagnoses of multiple sclerosis (chronic disease of the central nervous system), anxiety disorder (excessive feeling of uneasiness, worry and fear), and depression (persistent feeling of sadness, emptiness and loss of interest in life). During an observation on 11/12/25, at 11:15 a.m. two top enabler bars were present on Resident R4's bed. Review of Resident R4's clinical record on 11/12/25, failed to include an assessment for the resident's enabler bar usage and failed to include the development of goals and interventions related to the resident's enable bar usage in the care plan. Review of the clinical record indicated Resident R32 was admitted to the facility on [DATE]. Review of Resident R32's MDS dated [DATE], indicated diagnoses of dysphagia (difficulty swallowing), malnutrition (imbalance in the nutrients the body needs and the nutrients it gets), and anxiety disorder (excessive feeling of uneasiness, worry and fear). During an observation on 11/12/25, at 10:15 a.m. two top enabler bars were present on Resident R32's bed. Review of Resident R32's clinical record on 11/12/25, failed to include an assessment for the resident's enabler bar usage and failed to include the development of goals and interventions related to the resident's enable bar usage in the care plan. Review of the clinical record indicated Resident R42 was admitted to the facility on [DATE]. Review of Resident R42's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/17/25, indicated diagnoses of cerebrovascular accident (stroke sudden loss of blood flow to part of the brain), diabetes mellitus (high blood sugar), and malnutrition (imbalance in the nutrients the body needs and the nutrients it gets). During an observation on 11/12/25, at 12:00 p.m. two top enabler bars were present on Resident R42's bed. Review of Resident R42's clinical record on 11/12/25, failed to include an assessment for the resident's enabler bar usage and failed to include the development of goals and interventions related to the resident's enable bar usage in the care plan. During an interview on 11/13/25, at 9:50 a.m. the Director of Nursing confirmed that the facility failed to maintain accurate resident care plans and conduct ongoing accurate assessments to ensure that bedrails/enabler bars were used to meet residents' needs and the risks associated with bedrail usage for three of six residents as required. 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.		

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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. Based on resident and staff interviews, and facility documents (grievance and staffing) reviews, 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 11 of 18 residents (Residents R700, R701, R702, R703, R704, R705, 706 and 707. R41, R50 and R29). Review of a grievance dated 9/10/25, indicated Residents R41 and R50 had indicated that Nurse Aides on the afternoon shifts on the past Sunday (9/7) and Monday (9/8) did not answer call bells and used loud voice. During an interview on 11/12/25, at 12:10 p.m., the DON stated that she did not investigate the grievance and the facility failed to provide sufficient staffing to provide services to attain or maintain the resident's highest practical well-being. During an interview on 11/13/25, at 8:40 a.m., Resident R29 stated that the facility staff do not answer call bells timely and she has waited at least an hour to get assistance. During an interview on 11/13/25, at 8:50 a.m., the DON confirmed that the facility failed to provide sufficient staffing to provide services to attain or maintain the resident's highest practical well-being.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, facility policy, and staff interviews it was determined that the facility failed to prevent the potential for cross-contamination during glucometer usage for three of four residents (Resident R42, R14, and R46), and medication administration for one of six residents (Resident R5). Findings Include: A review of the facility policy Obtaining a Fingerstick Glucose Level reviewed 7/31/25, Steps in the Procedure, Step #3: Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses. Step #18: Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. A review of the facility policy Administering Medications reviewed 7/31/25, indicated staff follows established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications. During an observation 11/12/25, at 11:35 a.m. Registered Nurse (RN) Employee E7 did not clean the glucometer prior to, or after using it to check Resident R42's blood sugar level. During an observation on 11/12/25, at 11:45 a.m. RN Employee E7 did not clean the glucometer prior to, or after using it to check Resident R14's blood sugar level. During an observation on 11/12/25, at 11:50 a.m. RN Employee E7 did not clean the glucometer prior to, using it to check Resident R46's blood sugar level, after using the glucometer RN Employee E7 put alcohol-based hand sanitizer (ABHS) in his hands and proceeded to rub his hands together and picked up the glucometer and rubbed it with his hands and the ABHS. During an interview on 11/12/25, at 12:25 p.m. RN Employee E7 stated he was never told what to clean the glucometer with. During an observation on 11/13/25, at 9:20 a.m. RN Employee E7 prepared Resident R5's oral medications at the medication cart. He touched an allergy relief tablet with his bare hands while dispensing from a multi-use over-the-counter medication. At 9:27, RN Employee E7 touched two beet root gummies with his bare hands while placing them into the medication cup for Resident R5. During an interview on 11/13/25, at 9:33 a.m. RN Employee E7 stated he did not know that he was not to touch resident medications with his bare hands. During an interview on 11/13/25, at 10:30 a.m. the Director of Nursing confirmed that the facility failed to prevent the potential for cross-contamination during the use of the glucometer, and medication administration. 28 Pa. Code: S201.14 (a) Responsibility of licensee. 28 Pa. Code: S201.18 (b)(1)(e)(1) Management.		

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Some	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observations and a staff interview, it was determined the facility failed to post a statement that the resident may file a complaint with the state agency and had incomplete information for Adult Protective Services (APS) and the Medicaid Fraud Unit, as required within the building. Findings include: The facility must post, in a form and manner accessible and understandable to residents, resident representatives; a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit. Observations conducted on 11/13/25, at approximately 2:00 p.m., revealed a posting board containing a portion of the required facility postings, between nursing unit's hall 1 and hall 2. The posting board access was blocked by two carts station in front of the posting board. During rounds and an interview, on 11/13/25, at approximately 2:30 p.m., with the Nursing Home Administrator (NHA), confirmed the posting board was blocked by two carts and that that the facility failed to post a statement that the resident may file a complaint with the state agency and had incomplete information for APS and the Medicaid Fraud Unit, as required within the building. 28 Pa. Code: 201.14(a)Responsibility of licensee. 28 Pa. Code: 201.18(e) Management.		

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F 0579 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide information about how to apply for and use Medicare and Medicaid benefits. Based on observations and a staff interview, it was determined that the facility failed to display (for residents and/or their responsible person) written information on how to apply for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid as required, in the building. Findings include: The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Observations conducted on 11/13/25, at approximately 2:00 p.m., revealed a posting board absent of information on the application process for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid, between nursing unit's hall 1 and hall 2. The posting board access was blocked by two carts station in front of the posting board. During rounds and an interview, on 11/13/25, at approximately 2:30 p.m. with the Nursing Home Administrator (NHA), confirmed the posting board was blocked by two carts and that the facility failed to display (for residents and/or their responsible person) written information on applying for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid as required, in the building. 28 Pa. Code: 201.14(a)Responsibility of licensee. 28 Pa. Code: 201.18(e) Management.		