

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/30/2026
NAME OF PROVIDER OR SUPPLIER  McMurray Hills Rehabilitation and Healthcare Cente		STREET ADDRESS, CITY, STATE, ZIP CODE  249 West McMurray Road McMurray, PA 15317	
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)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>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 11 of 49 residents (R1, R2, R12, R13, R14, R15, R16, R17, R18, R19, and R20). Findings include: Review of the facility policy Identifying Exploitation, Theft and Misappropriation of Resident Property dated 9/1/25, 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., indicated misappropriation of resident property is strictly prohibited, with drug diversion (taking the resident's medication) provided as an example of misappropriation. Review of information submitted to the state survey agency indicated that on 3/23/26, at 11:00 a.m., Center supervisor was notified by anonymous male caller that he had found a purse on the side of the road which contained multiple medication cards on several residents of [the facility]. DON (Director of Nursing) and Administrator presented to police station. Shown contents of pink bag with multiple medications and Tuberculin employment skin testing record and orientation sheet - both with name [Licensed Practical Nurse (LPN) Employee E1] written on them. There were eleven resident medications in individual dispense bags. No controlled substances are identified. The medication dates and assignments areas coincided with LPN Employee E1's assignments on these two days / shifts. MARS (Medication Administration Records) reviewed for all residents on these two assignment areas on these dates and shifts - all medications are signed out by this LPN. The submission listed Residents R1, R2, R12, R13, R14, R15, R16, R17, R18, R19, and R20. Review of a facility submitted Report Form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property completed 3/27/26, indicated that facility substantiated the allegation of misappropriation and documented, Police will be conducting their own investigation. LPN has been terminated from employment, she has admitted they were in her purse off property. During an interview on 3/30/26, at approximately 1:00 p.m. the Nursing Home Administrator and the Interim Director of Nursing confirmed that the facility failed to ensure that residents are free from misappropriation of property for 11 of 49 residents. 28 Pa. Code: 211.12 (d)(1)(5) Nursing services.28 Pa. Code: 201.29(j) Resident rights.</p>		

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on review of facility policy and clinical records and staff interviews it was determined that the facility failed to make certain controlled substances were accounted for accurately for eleven of sixteen residents (Resident R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, and R11). Findings include: The facility policy Controlled Substances last reviewed 9/1/25, indicated Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimized the time between loss/diversion and detection /follow-up. Review of Resident R1's MAR (medication administration record) for March 2026, revealed an order for oxycodone 10mg (a narcotic pain medication used to treat moderate to severe pain) to be given every morning and additionally every six hours as needed for pain. Three as needed administrations were documented on the MAR from 3/16/26, through 3/30/26. Review of Resident R1's Controlled Drug Record indicated that six additional doses of oxycodone were signed out without corresponding documentation of administration to the resident on 3/18/26 (x2 doses), 3/23/26, 3/24/26, 3/26/26, and 3/27/26. Review of Resident R2's MAR for March 2026, revealed an order for Tramadol 50mg (an opioid pain medication used to treat moderate to severe pain) to be given every six hours as needed for pain. Zero administrations were documented from 3/1/26, through 3/30/26. Review of Resident R2's Controlled Drug Record indicated that two doses of Tramadol were signed out without corresponding documentation of administration to the resident on 3/15/26, and 3/16/26. Review of Resident R3's MAR for March 2026, revealed an order for oxycodone 5mg to be given every six hours for pain. Seven administrations were documented from 3/20/26, through 3/30/26. Review of Resident R3's Controlled Drug Record indicated that nine additional doses of oxycodone were signed out without corresponding documentation of administration to the resident on 3/21/26 (x2 doses), 3/22/26, 3/23/26, 3/24/26 (x2 doses), 3/26/26, 3/28/26, and 3/29/26. Review of Resident R4's MAR for March 2026, revealed an order for oxycodone 5mg to be given every six hours as needed for pain. Five administrations were documented on the MAR from 3/4/26, through 3/30/26. Review of Resident R4's Controlled Drug Record indicated that thirteen additional doses of oxycodone were signed out without corresponding documentation of administration to the resident on 3/4/26, 3/6/26, 3/9/26, 3/10/26, 3/12/26, 3/15/26 (x2 doses), 3/16/26, 3/17/26, 3/18/26 (x2 doses), 3/22/26, and 3/24/26 (x2 doses). Review of Resident R5's MAR for March 2026, revealed an order for oxycodone 5mg to be given every six hours as needed for moderate pain. Eight administrations were documented on the MAR from 3/11/26, through 3/30/26. Review of Resident R5's Controlled Drug Record indicated that sixteen additional doses of oxycodone were signed out without corresponding documentation of administration to the resident on 3/11/26 (x2 doses), 3/12/26, 3/13/26, 3/14/26, 3/15/26 (x2 doses), 3/16/26 (x3 doses), 3/18/26 (x2 doses), 3/19/26, 3/24/26, 3/25/26, and 3/28/26. Review of Resident R6's MAR for March 2026, revealed an order for oxycodone 5mg to be given every six hours as needed for moderate pain and two tablets every six hours for severe pain. Four administrations of five milligram doses were documented on the MAR from 3/18/26, through 3/30/26. Review of Resident R6's Controlled Drug Record indicated that four additional doses of oxycodone were signed out without corresponding documentation of administration to the resident on 3/18/26 (5 mg), 3/18/26 (10 mg signed out, documented on MAR as 5 mg), 3/29/26 (10 mg), and 3/23/26 (5 mg). Review of Resident R7's MAR for March 2026, revealed an order for Tramadol 50mg to be given every six hours as needed for pain. One administration was documented on the MAR from 3/13/26, through 3/19/26. Review of Resident R7's Controlled Drug Record indicated that one additional dose of Tramadol was signed out without corresponding documentation of administration to the resident on 3/16/26. Review of Resident R8's MAR for March 2026, revealed an order for oxycodone 5 mg to be given every four hours for moderate pain. One administration was documented on the MAR from 3/2/26, through 3/23/26. Review of Resident R8's Controlled Drug Record indicated that one</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>additional dose of oxycodone was signed out without corresponding documentation of administration to the resident on 3/10/26. Review of Resident R9's MAR for March 2026, revealed an order for hydrocodone/ acetaminophen 5-325 (hydrocodone, an opiate narcotic pain medication and acetaminophen) to be given twice daily as needed for pain. Two administrations were documented on the MAR from 3/2/26, through 3/9/26. Review of Resident R9's Controlled Drug Record indicated that three additional doses of hydrocodone/ acetaminophen were signed out without corresponding documentation of administration to the resident on 3/3/26 (x2 doses) and 3/4/26. Review of Resident R10's MAR for March 2026, revealed an order for Tramadol 50mg to be given every twelve hours as needed for severe pain. Three administrations were documented on the MAR from 3/15/26, through 3/30/26. Review of Resident R10's Controlled Drug Record indicated that four additional doses of Tramadol were signed out without corresponding documentation of administration to the resident on 3/15/26, 3/26/26, 3/27/26, and 3/29/26. Review of Resident R11's MAR for March 2026, revealed an order for Tramadol 50mg to be given every six hours as needed for severe pain. Three administrations were documented on the MAR from 3/10/26, through 3/30/26. Review of Resident R11's Controlled Drug Record indicated that twelve additional doses of Tramadol were signed out without corresponding documentation of administration to the resident on 3/13/26, 3/14/26, 3/17/26, 3/18/26, 3/19/26 (x2 doses), 3/20/26, 3/21/26, 3/22/26, 3/26/26, 3/27/26, and 3/29/26. During an interview on 3/30/26, at approximately 1:00 p.m. the Nursing Home Administrator and the Interim Director of Nursing confirmed that the facility failed to make certain controlled substances were accounted for accurately for eleven of sixteen residents. 28 Pa. Code: 211.9(a)(1)(j) Pharmacy services.28 Pa. Code: 211.12(d)(1)(5) Nursing services.</p>		