

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395295	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2025
NAME OF PROVIDER OR SUPPLIER Wecare at Murrysville Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3300 Logan Ferry Road Murrysville, PA 15668	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop a comprehensive care plan that included specific and individualized interventions to address the care needs of residents for one of six residents (Resident R1) reviewed, relating to wandering/elopement. Findings include: Review of facility policy Care Plans, Comprehensive Person-Centered dated 5/30/35, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implement for each resident. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents conditions change. Review of facility policy Wandering and Elopement dated 5/30/25, indicated the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Elopement risk screenings with be completed on residents upon admission, re-admission, quarterly, significant change in status, and as needed. When a resident is identified to be at risk for elopement, this will be care planned along with interventions identified to reduce the resident's risk for elopement. Wander guard tag/bracelet shall be placed on resident. Review of the clinical record indicated Resident R1 was admitted to facility 8/7/25. Review of Resident 1's Minimum Data Set (MDS, periodic assessment of resident care needs) dated 8/10/25, included diagnoses of unspecified intercranial injury with loss of consciousness, hepatitis C (viral infection that causes liver swelling (inflammation), potentially leading to serious liver damage) , and liver cirrhosis (chronic condition characterized by replacement of healthy liver tissue with scar tissue, leading to impaired liver function and potentially life-threatening complications). Review of Section E: Behavior indicated Resident R1 had failed to display wandering behaviors. Review of clinical record form WEC: Admission/Re-Admit Eval, Section N Elopement Risk Evaluation dated 8/7/25, indicated Resident R1 as No, not at risk for elopement. Review of Resident R1's physician order dated 8/8/25, indicated Wander guard (wander management system designed to ensure safety of individuals): Check placement of Wander guard every shift. Monitor skin integrity every shift. RLE (right lower extremity) every shift for history of Wandering. Review of Resident R1's physician order dated 8/8/25, indicated to verify Wander Guard functionality every HS (hour of sleep) every night shift for Wander Guard verify functionality. Review of Resident R1's clinical record failed to indicate any documentation or assessment of wandering or elopement behaviors resulting in the use of a Wander Guard. Review of Resident R1's clinical progress note on 8/12/25, at 6:55p.m, identified as a late entry, revealed that Registered Nurse (RN) Employee E1 received notification from a staff member who was outside the facility that this resident (R1) was in the front of the building. Nurse Aide stated that she was with the resident in the front of the building. Resident R1 was immediately brought back into the facility. Resident R1 was taken to his room for a complete head to toe assessment with no injuries noted. Review of Resident R1 current care plan on 8/27/25, initiated 8/8/25, failed to indicate that a plan of care was developed from 8/8/25, through 8/12/25, for interventions related to use of a Wander Guard, as well as failing to establish problem area and their causes, and measurable objectives for use of the Wander Guard. During an interview on 8/27/25, at 3:30 p.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility failed to develop a comprehensive care plan that included specific and individualized interventions to address the care needs for one of six residents (Resident R1) reviewed, relating to wandering/elopement. 28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 211.12 (d)(5) Nursing Services.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, facility documents, and staff interviews, it was determined that the facility failed to provide adequate supervision resulting in an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one of six residents (Resident R1). Findings include: Review of facility policy Wandering and Elopement dated 5/30/25, indicated the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Elopement risk screenings will be completed on residents upon admission, re-admission, quarterly, significant change in status, and as needed. 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 indicated Resident R1 was admitted to facility 8/7/25. Review of Resident R1's Minimum Data Set (MDS, periodic assessment of resident care needs) dated 8/10/25, included diagnoses of unspecified intracranial injury with loss of consciousness, hepatitis C (viral infection that causes liver swelling (inflammation), potentially leading to serious liver damage), and liver cirrhosis (chronic condition characterized by replacement of healthy liver tissue with scar tissue, leading to impaired liver function and potentially life-threatening complications). Review of Section C: Cognitive Patterns, Questions C0500 BIMS Summary Score revealed Resident R1's score to be 6, severe cognitive impairment. Review of Section E: Behavior indicated Resident R1 had failed to display wandering behaviors. Review of clinical record form WEC: Admission/Re-Admit Eval, Section N Elopement Risk Evaluation dated 8/7/25, indicated Resident R1 as No, not at risk for elopement. Review of Resident R1's physician order dated 8/8/25, indicated Wander guard (wander management system designed to ensure safety of individuals): Check placement of Wander guard every shift. Monitor skin integrity every shift. RLE (right lower extremity) every shift for history of Wandering. Review of Resident R1's physician order dated 8/8/25, indicated to verify Wander Guard functionality every HS (hour of sleep) every night shift for Wander Guard verify functionality. Review of Resident R1's clinical record failed to indicate any documentation or assessment of wandering or elopement behaviors resulting in the use of a Wander Guard. Review of Resident R1's plan of care, initiated 8/8/25, indicated a focus regarding cognition: (R1) has impaired cognitive function or impaired thought processes in regard to TBI (traumatic brain injury), with intervention to cue, reorient, and supervise as needed. Review of Resident R1's clinical progress note on 8/12/25, at 6:55p.m, identified as a late entry, revealed that Registered Nurse (RN) Employee E1 received notification from a staff member who was outside the facility that this resident (R1) was in the front of the building. Nurse Aide stated that she was with the resident in the front of the building. Resident R1 was immediately brought back into the facility. Resident R1 was taken to his room for a complete head to toe assessment with no injuries noted. Resident R1 dressed in T-shirt, shorts, tennis shoes. Temperature outside 80 degrees. Neurological checks were within normal limits and resident was able to move all extremities. Orders received for neurological checks per facility protocol and every 15 minute checks. Resident R1 was moved to room [ROOM NUMBER]W for closer monitoring. Staff person positioned at exit door until service and security established. Review of facility provided witness statement provided by RN Employee E1, dated 8/12/25, at 6:55 p.m., indicated this supervisor received notification from a staff member who was outside the facility that this resident (R1) was in the front of the building. Nurse Aide stated that she was with this resident in the front of the building. Resident R1 was immediately brought into the facility. All doors checked and found one door down 100 hall not secure. Remaining doors locked and secure. During an interview on 8/27/25, at 3:30 p.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility failed to provide adequate supervision to prevent elopement for one of six residents (Resident R1). 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services</p>		