

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  12/17/2025
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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</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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(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 - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to conduct a thorough investigation of an allegation of abuse for one of two residents (Resident R1). Findings include: Review of facility Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy dated 5/30/25, indicated all reports of resident abuse, neglect, exploitation or theft/misappropriation of resident property are reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/8/25, indicated diagnoses of depression, chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), and heart failure (a progressive heart disease that affects pumping action of the heart muscles). Resident R1's MDS assessment section C0200 Brief Interview for Mental Status (BIMS, 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. Resident R1's BIMS score was 14 indicating Resident R1 was cognitively intact. Review of facility documentation submitted to the state survey office dated 12/3/25, at 9:00 a.m. indicated that Resident R1 alleged Nurse Aide (NA) Employee E1 grabbed her arm to force her to go to the dining room for lunch. Review of Resident R1's progress note dated 12/3/25, by Registered Nurse Employee E2 indicated Resident R1's family member called the facility claiming Resident R1 was mishandled by a nurse aide. Resident on her part reported her right arm was sore because NA Employee E1 grabbed her arm forcefully during lunch time. On assessment of the right arm, nothing was seen that was unusual, skin was dry and intact. An X-ray was ordered for the right arm. Review of Resident R1's statement obtained on 12/4/25, by Licensed Practical Nurse (LPN) Employee E3 stated the following, They attempted to take me to therapy, but there was a long line, and I wanted to return to my room. I began to take myself back to my room from therapy and NA Employee E1 attempted to take me elsewhere (dining room), so I held onto the hand railing. He then grabbed my right arm, and it hurt. He should not be putting his hands on me no matter what. Two nurses then approached me, assisted me back to my room, and helped me into bed. During a review of witness statements, including NA Employee E1's, provided by the facility on 12/17/25, at 10:00 a.m. indicated that witness statements were completed and focused on care and treatment that was provided to Resident R1 while in her room. The witness' statements failed to include any information about an incident involving Resident R1's allegation of forcefully moving her hand off the handrail in the hallway. During an interview on 12/17/25, at 11:22 a.m. with NA Employee E1 indicated that nursing supervisor asked him to write a statement concerning providing care to Resident R1 on 12/3/25. She told me that I was being investigated and to write a statement about the care I provided. I wrote about helping resident out of bed with others in the room. Nobody asked me about the resident grabbing the handrail. We took her to the dining room, where trays were ready to be passed to all the residents. Resident R1 was going back to her room, and I asked that she not transfer back to bed without assistance because she may fall. Resident R1 stated she didn't care and that she was getting back into bed. She started to self-propel towards her room. I approached her and turned her wheelchair back towards the dining room so she wouldn't self-transfer and fall. She grabbed the handrail. I lifted her arm that she had a hold of the railing with so I could take her back to the dining room. I lifted her arm easily. Resident R1 never complained about me or the incident the rest of the day. During an interview on 12/17/25, at 1:13 p.m. Director of Nursing stated that the facility failed to fully investigate Resident R1's allegation of abuse and that five out of six witness statements failed to reveal information about the actual allegation of NA Employee E1 forcefully grabbing Resident R1's arm which was reported by resident and reported to the state survey office. During an interview on 12/17/25, at 2:00 p.m. the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to conduct a thorough investigation of an allegation of abuse for one of two residents (Resident R1). 28 Pa Code: 201.18 (e)(1)(2) Management. 28 Pa Code: 201.29 (a)(c) Resident Rights. 28 Pa Code: 211.12 (c)(d)(1)(3)(5) Nursing services.</p>		