

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: 395633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Havencrest Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1277 Country Club Road Monongahela, PA 15063	
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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on staff interview it was determined that the facility failed to employ a qualified Food Service Director to manage the daily operations of the Dietary Department for 12 out of 12 months (February 2025 through February 2026). Findings include: During an interview on 2/8/26, at 10:28 a.m., the Dietary Supervisor Employee E10 stated that she is not yet certified and that the Dietician comes in Wednesday's and sometimes Tuesday or Friday depending in the need. During an interview on 2/8/26, at 12:00 p.m., the Nursing Home Administrator confirmed that the facility failed to provide documented evidence that Dietary Supervisor Employee E10 met the qualifications for the position of Food Service Director. Pa Code: 201.18(e)(6) Management.		

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 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 observation and staff interview, it was determined that the facility failed to properly store food products in the reach in cooler which created the potential for cross contamination (Main Kitchen). Findings include: During an observation on 2/8/26, from 10:30 a.m., through 10:54 a.m., the following was observed: Large bowl of pudding in cooler, uncovered and undated Two large bags of lettuce were liquified and spoiled A container of broth was in cooler with no date of being made or expiration. During an interview on 2/8/26, at 10:54 a.m., the Dietary Supervisor Employee E10 confirmed that the facility failed to properly store food products in the reach in cooler which created the potential for cross contamination (Main Kitchen). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(3) Management.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Keep all essential equipment working safely. Based on a review of observations and staff interviews, it was determined that the facility failed to ensure the dish machine was in proper working order in the Main Kitchen. Findings include: During an observation on 2/8/26, at 10:30 a.m., the dish machine wash cycle is required to reach at least 160 degrees, the machine was reaching 150 then immediately dropped to 145 degrees when ran three times. During an observation on 2/9/26, at 9:48 a.m., of the dish machine cycling, the Corporate Dietician Employee E11 stated that the wash thermometer is nonfunctioning, and the facility must use temperature strips, which did identify the was cycle reaching 180 degrees and confirmed the facility was not aware that the dishwasher was inoperable until the morning of 2/9/26.28 Pa Code:201.14(a) Responsibility of Licensee		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policy and staff interviews, it was determined that the facility failed to provide a safe, clean, comfortable, and homelike environment on two of two nursing halls (front hall and back hall). Findings include: During an observation on 2/11/2026 from 10:20 a.m., through 11:10 a.m., the following was identified: room [ROOM NUMBER]- floor was soiled with black marks and debris room [ROOM NUMBER] - bed b had debris under bed and the wall behind headboard was scraped and chipped paint rooms [ROOM NUMBERS] shared bathrooms had bubbling paint behind toilet wall with missing paint rooms [ROOM NUMBERS] had soiled floors with debris and black marks room [ROOM NUMBER]-with 4 beds had soiled privacy curtains, walls with chipped paint and the floors under the fall mats had not been cleaned with black marks room [ROOM NUMBER]- had soiled privacy curtains, the wall behind D bed had bubbled paint and tape over wall, the mattress on the bed was very soiled with white substances and appeared very worn in the center. The baseboard near the cabinets was broken, there was a small hole near the entrance of the bathroom, the wall in the bathroom was scraped with chipped paint room [ROOM NUMBER]- had soiled privacy curtains, the floor was soiled with black marks and floor under mats were not cleaned with debris and black marks room [ROOM NUMBER]- the floor under head of bed had debris Rooms 18, 20, 21, 24, 25 and 26 - had soiled floors with black marks Ceiling of the Front Hall and above the nurse's station had areas of chipped paint, broken tiles and in need of repair. During an interview on 2/11/26, at 11:09 a.m., the Maintenance Director Employee E1 confirmed the identified areas. During an interview on 2/11/26, at 11:22 a.m. the Regional Consultant Employee E2 was made aware of the areas requiring the Laundry/ Housekeeping Manager's review as he was not available and confirmed that the facility failed to provide a safe, clean, comfortable, and homelike environment on two of two nursing halls (front Hall and Back Hall). 28 Pa. Code: 207.2(a) Administrator's responsibility. 28 Pa. Code: 201.29(k) Resident rights.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of professional standards of practice, facility policy, clinical record review and staff interview, it was determined that the facility failed to develop and implement care and services consistent with professional standards of practice to prevent the development of a pressure ulcer that developed into a Stage IV pressure ulcer (severe full thickness wound extending to exposed muscle, tendon or bone often with slough, eschar and tunneling) to the coccyx extending to bilateral buttocks and a denuded tissues (tissue that had been stripped of the first layer of skin) of the scrotum for one of three residents reviewed (Resident R4). Findings include: Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e., support surfaces, repositioning, and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement, and wound cleansing; using adjunctive therapies; and considering possible surgical repair. According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, standardized pressure ulcer risk assessment, and care planning and implementation to address the areas of risk. Review of the facility policy Pressure Ulcer/ Injury Risk Assessment reviewed on 10/8/25, indicated the policy is provide guidelines for the structured assessment and identification of residents at risk of developing pressure ulcers/injuries. Risk Factors include impaired/decreased mobility, exposure of skin to urinary and fecal incontinence and co-morbidities. The assessment should be conducted as soon as possible after admission, but no later than eight hours after admission and repeated weekly for the first four weeks. Once the assessment is conducted and risk factors are identified, a care plan is created. Review of the facility policy Prevention of Pressure Ulcers/ Injuries last reviewed on 10/8/25, indicated the resident is assessed on admission. Staff are to inspect the skin on a daily basis when assisting with personal care or ADLs. During an interview on 2/9/26, at 1:45 p.m., the Director of Nursing stated that since the current administration staff came, the facility nursing staff are to perform a second skin assessment two days after admission skin assessment is completed, that is what they do to go above and beyond. Review of the clinical record indicated that Resident R4 was admitted to the facility on [DATE], with diagnoses which included morbid obesity, high blood pressure, heart failure and cellulitis of his RLE with a non-healing right heel wound, which had been debrided. An MDS (Minimum Data Set- a periodic review of resident care needs) dated 12/17/25, indicated the diagnoses remained current. The MDS indicated Resident R4 required assistance of two staff for bed mobility. Review of Resident R4's initial skin assessment and Braden Scale assessment (an evidence- based tool used by healthcare professionals to assess a patient's risk of developing pressure injuries) dated 2/25/25, identified Resident R4 as at risk. Review of the current pressure ulcer list provided by the facility identified Resident R4 had a facility acquired Stage IV pressure injury of his coccyx extending to bilateral buttocks. The date indicated as being identified was 3/4/25. Review of the clinical record revealed a progress noted dated 3/4/25, from Nurse Practitioner (NP) Employee E3 which indicated a facility acquired coccyx wound measuring 14cm x 8cm x 0.1 cm with 70% eschar and 30% slough of the coccyx, extending to bilateral upper thighs, staged as a Stage IV pressure injury and also a 4.5 cm x 5 cm x 0.1 cm denuded area full thickness of his scrotum. Review of the clinical record did not include any skin assessments or documentation being completed by staff prior to the identification of the Nurse Practitioner's assessment as indicated above. During an interview on 2/9/26, at 2:17 p.m., with NP Employee E3 stated she first saw the wounds on 3/4/25, when she was asked to assess them as they had been identified. She said she followed the resident until July 2025. She stated that every time she came to re-assess the wounds, Resident R4 (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not have a dressing covering the wounds and the wounds had to be debrided several times in an attempt to heal them. NP Employee E3 stated that Resident R4 had a lot of incontinence of both bowel and bladder. She stated that the initial wound assessment did identify the skin to be darkened, as if it was a Deep Tissue Injury prior to opening to a stage IV. Review of the clinical record did not include documentation of how Resident R4's wounds had not been identified prior to the encounter of 3/4/25. Review of Resident R4's physician orders did not include turning and positioning every two hours, nutritional interventions, or nursing interventions until 3/4/25, after the wounds developed. During an interview on 2/9/26, at 1:45 p.m., the Director of Nursing confirmed that the facility failed to ensure that clinical practice guidelines were followed and interventions to prevent pressure ulcers were implemented for Resident R4.28 Pa. Code 211.10(c)(d) Resident care policies28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services		