

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395653	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER Woodhaven Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 McGinley Road Monroeville, PA 15146	
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>39311</p> <p>Based on review of facility policy, observations, resident, and staff interviews, it was determined that the facility failed to assess and care plan for self-administration of medications for three of twelve residents (Residents R1, R2, and R3).</p> <p>Findings include:</p> <p>Review of the facility policy General Dose Preparation and Medication Administration dated 6/7/24, indicated to observe resident consumption of medication.</p> <p>During an observation on 3/14/25, at 10:08 a.m. Resident R1 was reclined in bed. On her over-bed table a medicine cup was observed on its side, with one pill still in it and another pill on the over-bed table.</p> <p>During an observation on 3/14/25, at 10:08 a.m. Resident R2 was reclined in bed. On her over-bed table a medicine cup was observed with one pill still in.</p> <p>During an observation on 3/14/25, at 2:06 p.m. a pill was observed on the floor or Resident R3's room.</p> <p>Review of the clinical records for Resident R1, R2, and R3 failed to reveal an assessment for the self-administration of medications or a plan of care developed for self-administration of medications.</p> <p>During an interview on 3/14/25, at approximately 3:15 p.m. the Nursing Home Administrator confirmed the facility failed to assess and care plan for self-administration of medications for three of twelve residents.</p> <p>28. Pa. Code 211.12(d)(1)(2) Nursing services.</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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>39311</p> <p>Based on review of facility policy, resident observations, resident and staff interviews, and grievance review, 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 of 16 of 22 residents (Residents R1, R2, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17).</p> <p>Findings Include:</p> <p>Review of the facility policy Resident Communication and Call Light Policy dated 6/27/24, indicated staff will respond to call lights promptly.</p> <p>During an observation on 3/14/25, at 9:59 a.m. Resident R4 room smelled strongly of urine and Resident R4 had messy, unkempt hair.</p> <p>During an interview on 3/14/25, at 1:02 a.m. Resident R5 was observed to have messy, unkempt hair.</p> <p>During an interview on 3/14/25, at 10:03 a.m. Resident R6, when asked if call lights took a long time to be answered stated, Sometimes it takes a long time. Resident R6 further stated his medications have been 30-90 minutes late.</p> <p>During an interview with Residents R1 and Resident R2 on 3/14/25, at 10:08 a.m. Resident R2 stated that she hears staff in the hall but that call lights have taken up to two hours and often staff don't return when they state they will. Resident R2 stated that she does not receive enough showers. Resident R2 stated that she has been told by nurse aides not to request assistance between 4:30 p.m. to 5:30 p.m. since staff are too busy to help her. Resident R2 a few days ago her niece had brought her and her roommate pizza, the that the leftovers were placed in the unit refrigerator. Resident R2 stated that when she and her roommate asked for it to be heated up for dinner, it was no longer in the refrigerator, and staff told her, If you got your tray, that's what you are eating. Resident R2 stated she and her roommate hadn't eaten their dinner trays as they were expecting to eat their pizza. Later they were brought dry cereal, but no milk until 10:00 p.m., and that they had to pick at dry cereal for dinner. Resident R1 confirmed the above information in relation to the pizza, a lack of showers, stated that call light response is terrible, and when she asks for assistance the nursing staff roll their eyes at her. Resident R1 further stated that she has been directed to pee in my diaper when she asked to be placed on the bed pan. Resident R1 also stated, I need my hair brushed.</p> <p>During an observation on 3/14/25, at 10:22 a.m. Resident R7 was noted to have extremely long toenails, the room floor was dirty, and a trash can without a bag, laying its side, with breaks in the rim causing sharp edges.</p> <p>During an interview with Residents R8 and Resident R9 on 3/14/25, at 1:23 p.m. when asked if they felt the facility maintained enough nursing staff, both residents stated, No. Resident R8 stated call light response time depends and that she has been left on the bed pan too long. Resident R9 stated that call light response time depends and that she does not get enough showers.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 3/14/25, at 1:28 p.m. Resident R10 was noted to have very messy, unkempt hair.</p> <p>During an observation on 3/14/25, at 1:35 p.m. Resident R11 was noted to have a large amount of brown substance under her fingernails.</p> <p>During an observation on 3/14/25, at 1:38 p.m. Resident R12 was noted to have messy, unkempt hair.</p> <p>During an observation on 3/14/25, at 1:41 p.m. the call light monitor at the nurse's station revealed the call light for Resident R13 had been alarming for 18 minutes.</p> <p>During an interview on 3/14/25, at 1:45 p.m. Resident R14 stated that the facility sometimes does not have enough staff to shower him. Resident R14 stated that around 3:00 p.m. the day shift staff leave, but the afternoon shift staff are often late, leaving not enough aides to assist the residents.</p> <p>During an observation on 3/14/25, at 2:14 p.m. the call light monitor at the nurse's station revealed the call light for Resident R15 had been alarming for 17 minutes. Further continued observation revealed the call light was not answered until 2:18 p.m. (having alarmed 21 minutes).</p> <p>Review of a grievance filed on 2/27/25, on behalf of Resident R16 indicated a concern of, took an hour for staff to answer call lights and/or answered and said they would be back and it took an hour.</p> <p>Review of a grievance filed on 2/24/25, on behalf of Resident R17 indicated a concerns of, hasn't had a shower yet, call lights not answered in a timely fashion, didn't get breakfast or lunch.</p> <p>Review of grievances filed based on Resident Council concerns indicated:</p> <p>-2/26/25: the facility needs more staff.</p> <p>-1/29/25: overall staffing needs improvement, not arriving on time, not rounding enough, showers not being completed on designated days and times.</p> <p>During an interview on 3/14/25, at approximately 3:15 p.m. the Nursing Home Administrator confirmed 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 of 16 of 22 residents.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(e)(6) Management.</p> <p>28 Pa. Code: 201.20(a) Staff development.</p> <p>28 Pa. Code: 211.12(a)(c)(d)(1)(2)(3)(4) Nursing services.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311</p> <p>Based on facility policy, observation, clinical record review, and staff interview, it was determined that the facility failed to make certain that residents are free of significant medication errors for one of four residents (Resident R7).</p> <p>Findings include:</p> <p>Review of facility policy General Dose Preparation and Medication Administration reviewed 6/27/24, indicated that prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including, but not limited to: Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident.</p> <p>Review of the National Library of Medicine information dated , indicated insulin aspart is an injectable medication used to treat diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). It further stated, If you are using insulin aspart suspension to treat type 2 diabetes, it is usually injected within 15 minutes before a meal.</p> <p>Review of the clinical record indicated Resident R7 was originally admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 1/15/25, included diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), chronic kidney disease (gradual loss of kidney function), and type 2 diabetes.</p> <p>Review of the physician orders 6/30/23, indicated to give Resident R7 insulin aspart Inject SQ (subcutaneously) as per sliding scale before meals and at bedtime for diabetes mellitus II. The order provided times of 7:30 a.m., 11:30 a.m., 5:15 p.m., and 9:00 p.m.</p> <p>During an observation on 3/14/25, at 10:22 a.m. Resident R7 was observed receiving her insulin.</p> <p>During an interview on 3/14/25, at 10:23 a.m. Licensed Practical Nurse Employee E1 confirmed that this was Resident R7 ' s morning dose of insulin, scheduled before breakfast.</p> <p>Review of Resident R7 ' s Medication Administration History report revealed Resident R7 ' s morning insulin administration on 3/14/25, was documented at 8:53 a.m.</p> <p>During an interview on 3/14/25, at approximately 3:15 p.m. the Nursing Home Administrator confirmed that insulin administrations do not fall under the facility ' s flexible medication policy, and further confirmed that the facility failed to make certain that residents are free of significant medication errors for one of four residents.</p> <p>28 Pa. Code 207.2(a) Administrator's responsibility.</p> <p>28 Pa. Code: 211.10(c)(d) Resident care policies.</p> <p>(continued on next page)</p>		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code: 211.12(d)(1)(5) Nursing services.