STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395653	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodhaven Health & Rehab Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility documents, clinical record review, and staff interview, it was determined that the facility failed to provide appropriate care and services to two of five residents (Resident R10 and R11).Findings include: Review of facility policy Activities of Daily Living (ADLs), Supporting dated 6/1/25, indicated residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2025, Section G: Functional Abilities defined dependent as Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.Review of the clinical record revealed Resident R10 was admitted to the facility on [DATE].Review of the Minimum Data Set (MDSn - periodic assessment of resident care needs) dated 11/4/25, included diagnoses of hemiplegia, arthritis, and presence of a pressure ulcer. Review of Section GG: Functional Abilities indicated Resident R10 was totally dependent on staff for bed mobility (rolling left and right in bed) and transfers. Review of Resident R10's plan of care for Risk of Falls initiated 10/30/25, included the interventions of side rails for positioning.Review of Resident R10's plan of care for Self-Care and Mobility Deficits initiated 10/30/25, included the interventions assistance with Mobility: bed mobility (rolling left to right, sitting to lying and lying to sitting), transfers (sit-to-stand, bed-to-chair, toilet transfer), ambulation distances and use of stairs.Review of a progress note dated 11/28/25, at 4:44 p.m. indicated, Called into resident's room. Resident sitting on the floor beside her bed. LPN (licensed practical nurse) had been doing dressing change to her buttocks area and she was lying on her left side. LPN stated she was near the edge and slid off. Resident stated she did not hit her head (witnessed by LPN), landed on her knees then she sat down. Resident was not on her knees when this Supervisor entered the room. Assessed her for injury. No open areas, no bruising, no swelling noted. Moving her upper and lower extremities at baseline. No hip deformity. Neuro at baseline. She denies pain or discomfort. VSS. Resident was lifted back to bed with assist of 3. Call to son. Note to MD. Will continue to monitor for changes.Review of a witness statement dated 11/28/25, written by LPN Employee E1 stated, I was packing and redressing [Resident R10's] sacrum pressure sore. She was leaning on her left side near the edge of the bed and slipped off onto the floor. She did not hit her head but landed on her knees. After being helped back onto her bed she claims to be ok and has no pain. Vitals were taken and were normal.Review of a facility provided Post Fall Huddle Form dated 11/28/25, completed by Registered Nurse (RN) Employee E2 revealed the section of Current interventions was blank and did not document if Resident R10's side rails were in place. The section for the root cause was answered, Resident too close to edge of bed.During an interview on 12/12/25, at approximately3:15 p.m. , the Nursing Home Administrator confirmed that the resident's ability to maintain her own position during care is part of bed mobility, and if one staff member cannot do all of the effort (proving wound care while maintaining the resident's position on her side in bed) as Resident R10 is dependent on staff, then two staff members must provide care.Review of the clinical record revealed Resident R11 was initially admitted on [DATE], and readmitted to the facility on [DATE], and 10/7/25.Review of the MDS dated [DATE], included diagnoses of subdural hemorrhage and dementia without behavioral disturbances. Review of Section E: Behaviors failed to reveal documentation of hallucinations, delusions, physical or verbal behaviors to others, behavioral symptoms not toward others, rejection of care, or wandering behaviors.Review of Resident R11's facility diagnosis list failed to include diagnoses of agitation, anxiety, or behavioral disturbances.Review of Resident R11's plan of care for Altered Neurological Status initiated 7/13/25, included the interventions monitor for behavioral changes.Review of all progress notes from 10/1/25, through 12/6/25, failed to reveal documentation of incidences of behavioral disturbances, aggression, being physically inappropriate, or agitation.Review of a progress note dated 12/5/25, at 5:43 p.m. indicated, Resident confused and agitated since night shift. Reported to night RNS (RN Supervisor) to pass to dayshift to see if the doctor could order something to help resident rest. Throughout day shift resident yelling out, putting on the call bell. This nurse had entered room to attempt to comfort and help resident. Upon entering resident grabbed this nurse's wrist. Quickly redirected and asked resident what was wrong. removing bedding and throwing it on the floor. Asked this nurse to put in the laundry which this nurse did. Fluids given, poor appetite with meals. Continued to