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	01/12/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on review of facility policy, observations, and resident and staff interviews it was determined that the facility failed to provide activity of daily living (ADL) assistance for five of eleven residents (Residents R19, R20, R23, R25, and R26).Findings include: Review of the facility policy Resident Communication and Call Light Policy dated 6/27/24, indicated staff will respond to call lights promptly. During an observation on 1/12/26, at approximately 10:40 a.m. Resident R25 was seated in his wheelchair in front to the nurses' station wearing only a gown, tied at the neck, but pulled forward off of his shoulders. Resident R25's hair was unkempt and he had a crusted around his mouth. During an observation on 1/12/26, at 10:54 a.m. it was noted that a resident in Resident R19 and R20 was yelling for staff from behind a closed door. Observation at this nurse aides caring for residents and Licensed Practical Nurse Employee E3 standing at the medication cart. During an observation on 1/12/26, at 10:57 a.m., it was noted that the nurses' station call light monitor revealed that Resident R19 and R20's call light had been alarming for 17 minutes. During an observation on 1/12/26, at 11:01 a.m., it was noted that the nurses' station call light monitor revealed that Resident R19 and R20's call light had been alarming for 21 minutes when the surveyor was required to leave the floor. During an observation on 1/12/26, at 12:52 p.m. Nurse Aide Employee E1 was heard to be engaged in a personal conversation on her phone while feeding Resident R26. During an observation on 1/12/26, at approximately 12:55 p.m. Resident R23 yelled out the door to the surveyor for assistance. Resident R23 asked the surveyor to open the salt packet and sprinkle it on his french fries, open the ketchup packet and salad it onto his plate, and open the salad dressing packet and empty it onto his salad. During an interview on 1/12/26, at approximately 12:57 p.m. Nurse Aide Employee E2 confirmed that Resident R23 was unable to complete those tasks for himself, and confirmed that staff had not set up his lunch tray for him. During an interview on 1/12/26, at approximately 1:15 p.m. the Nursing Home Administrator confirmed the facility failed to provide activity of daily living assistance for failed to provide activity of daily living assistance for five of eleven residents. 28 PA. Code:201.18(b)(2) Management. 28 PA. Code:201.29(a) Resident's Rights.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and documents, clinical record review, and staff interview, it was determined that the facility failed to provide adequate supervision during bed mobility for one of six residents (Resident R1). This was identified as past-noncompliance.Findings include:Review of facility Resident Incident Accident Report Policy dated 8/27/25, indicated that an incident/accident is any occurrence which is not consistent with the routine care of a particular resident and all incident/accidents involving residents will be analyzed and reported.Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE].Review of the admission Observation form dated 12/13/25, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), hypertension with heart failure (a condition where the force of blood against your artery walls is too high and making your heart work harder), and chronic kidney disease (a long term condition where your kidneys are damaged and cannot filter your blood effectively).Review of Resident R1's New admission Nurse Hand to Hand Report dated 12/13/25, indicated Resident R1 had a transfer status of max assist x2 and a bed mobility of 2 to roll.Review of a progress note dated 12/14/25, at 9:00 p.m. indicated, This RNS notified that resident fell out of bed during personal care- rolled out of L sided of bed- hit face off chair armrest by head of bed- hit floor per CAN who was providing care. Resident observed lying supine with head/shoulders resting against chair- moderate bleeding from laceration on bridge of nose and laceration below R eye, subconjunctival bleeding in R eye. Resident able to state full name and date of birth , c/o double vision and pain at R eye.Review of an employee statement written by NA Employee E1 dated 12/14/25, indicated, I was giving care doing a full bed bath. I pulled him towards me then turned him on his side. [I] turned to get the sheet and brief to put on him. [That's] when he grab for the chair. Before I could even try to help, he hit the chair then on to the floor.On 10/9/25, the facility initiated a plan of correction that included:-Residents' representative aware.-Physician notified.-Whole house audit of residents to ensure accuracy of fall status.-Whole house education to obtain fall status in PCC by reviewing the Kardex and following each resident's plan of care.-All incidents are reviewed by the IDCP team and QAPI committee.During interviews completed on 12/30/25, three staff interviewed confirmed they had received education on the appropriate way checking a resident ' s transfer status and demonstrated how to navigate to the appropriate area in the electronic medical record system.Facility in compliance as of 12/30/25.During an interview on 12/30/25, at approximately 2:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to provide adequate supervision during bed mobility for one of six residents. This was identified as past noncompliance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on review of facility policy and documents, observations and staff interviews, it was determined that the facility failed to ensure an environment free from the potential spread of infection for 21 of 28 residents. Findings include: Review of the facility, Transmission Based Precautions and Isolation Policy last reviewed 8/27/25, indicated, When Airborne Precautions cannot be implemented due to lack of AIIR (Airborne Infection Isolation Room): Resident should be placed in a private room with the door closed, and healthcare staff provided with N95 or higher respirators. Signage indicating the appropriate type[s] of precautions and indicating that visitors should stop at Nurses Station before entering, will be placed on the resident's door. Staff will educate visitors regarding donning appropriate Personal Protection Equipment while adhering to the resident's right for privacy protection. Review of the Pennsylvania Department of Health Respiratory Virus Outbreak Toolkit dated 11/24/25, indicated, The LTCF (long-term care facility) should encourage masking of HCP (health care personnel), residents, and visitors during any respiratory virus outbreak. Masks help to prevent the spread of illness. This provides protection for the wearer (if using a fitted N95 or KN95) and protection for others (some surgical and N95/KN95). When a resident is suspected or confirmed to have a respiratory viral infection, additional precautions are needed to protect HCP during resident care. These precautions should be used in addition to standard precautions, source control, and proper hand hygiene. Proper institution of TBP (transmission-based precautions) includes placement in a private room, if available. The toolkit further stated that for SARS-CoV-2 (Covid-19) airborne, contact, and eye protection should be used, per the United States Department of Health and Human Services, Centers for Disease Control and Prevention, guidelines: Airborne Precautions indicated everyone must:Clean their hands, including before entering and when leaving the room.Put on a fit-tested N-95 or higher-level respirator before room entry.Remove respirator after exiting the room and closing the door.Door to room must remain closed. Contact Precautions indicated everyone must:Clean their hands, including before entering and when leaving the room.Put on gloves before room entry. Discard gloves before room exit.Put on gown before room entry. Discard gown before room exit.Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. Review of facility provided documentation on 01/12/26, revealed that 18 of the 28 current residents on the Two South Nursing Unit had tested positive for Covid-19. Review of the facility provided signage used to denote what precautions were required for entering rooms of residents with active Covid-19 stated:Everyone must: Clean their hands, including before entering and when leaving the room.Providers and staff must also: Gown, N-95 or PAPR (powered air purifying respirator), eye protection, and gloves for high-contact resident care.Room requirements: Keep door closed. Patient must wear surgical mask when leaving room. During an observation on 1/12/26, beginning at approximately 10:30 a.m. the following was observed on the Two South nursing unit: Room door for Resident R2 and R3 was open. PPE caddy hanging on door did not have N-95 masks available. No signage was hanging on or by the room door. Resident R2 had an active Covid-19 infection. Room door for Resident R4 and R5 had only signage for Enhanced Barrier Precautions. Both residents had active Covid-19 infections. Room door for Resident R6 and R7 had only signage for Enhanced Barrier Precautions. Resident R6 had an active Covid-19 infection. PPE caddy hanging on door for Resident R8 and R9's room did not have N-95 masks available. Resident R9 had an active Covid-19 infection. Room door for Resident R10 and R11 was open. Resident R10 had an active Covid-19 infection. Room door for Resident R12 and R13 was open. No PPE caddy hanging on door. Resident R12 had an active Covid-19 infection. Room door for Resident R14 and R15 had no signage was hanging on or by the room door. Both residents had active Covid-19 infections. Room door for Resident R16 had only signage (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for Enhanced Barrier Precautions. Resident R16 had an active Covid-19 infection. Resident R17's room door had signage for Covid-19 precautions. Neither Resident R17 nor former roommate Resident R18 were documented in the medical record for testing positive for Covid-19. Room door for Resident R19 and R20 had no signage hanging on or by the room door for transmission-based precautions. Both residents had active Covid-19 infections.Room door for Resident R21 and R22 was open. PPE caddy hanging on door did not have N-95 or surgical masks available. Both residents had active Covid-19 infections. During an interview on 1/12/26, at approximately 3:00 p.m. the Nursing Home Administrator confirmed the facility failed to ensure an environment free from the potential spread of infection for 21 of 28 residents. 28 Pa. code: 201.14(a) Responsibility of Licensee.28 Pa. Code: 201.18 (b)(1)(e)(1) Management.28 Pa. Code: 211.10(a)(d) Resident Care Policies.28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing Services.