STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395670	A. Building B. Wing	12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wecare at Monroeville Rehabilitation and Nsg Ctr	4142 Monroeville Blvd 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on review of facility policy, observations, and resident and staff interviews, it was determined that the facility failed to make accessible grievance boxes to residents in two of two locations (front hallway and rear hallway).Findings include: The Centers for Medicare & Medicaid Services (CMS) does not specify exact height requirements for grievance boxes in skilled nursing facilities. However, CMS mandates that grievance procedures be accessible to all residents, including those with disabilities, in compliance with the Americans with Disabilities Act (ADA). In Pennsylvania, the Department of Health incorporates by reference the federal requirements outlined in 42 CFR Part 483, Subpart B, which pertains to long-term care facilities. These regulations emphasize the importance of accessibility but do not provide additional specifications regarding grievance box placement. To ensure accessibility, the ADA Standards for Accessible Design recommend that operable parts, such as slots on grievance boxes, be mounted between 15 and 48 inches above the floor. This range accommodates individuals using wheelchairs and ensures usability for a broad range of residents. During an observation on 12/23/25, at 9:42 a.m. of the grievance box near the 100-unit nurses' station in the rear hall revealed the opening for grievance forms to be 57 inches from the floor. During an observation on 12/23/25, at 9:46 a.m. of the grievance box near the facility entry way in the front hall revealed the opening for grievance forms to be 57 inches from the floor. During an electronic interview on 12/29/25, at 2:45 p.m. the Nursing Home Administrator confirmed the facility failed to make accessible grievance boxes to residents in two of two locations. 28 PA Code: 201.18(e)(4) Management. 28 PA Code: 201.29(a)(b)(c) Resident 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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. Based on observations and staff interviews, it was determined that the facility failed to provide a clean and homelike environment on two of two nursing units and for seven of twelve residents.Findings include: Review of the facility policy Homelike Environment dated 6/1/25, indicated in part, The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include clean bed and bath linens that are in good condition. Review of information submitted to the Pennsylvania Department of Health on 12/22/25, indicated that Resident R21 had vomited under his bed on 12/18/25, and the dried vomit remained under his bed on 12/22/25. During an interview on 12/22/25, at 12:59 p.m. the Nursing Home Administrator confirmed that Resident R21's room had not been cleaned of the vomit from 12/18/25. During an observation on 12/22/25, at 1:50 p.m. Resident R20's room was noted to have food on the floor with a smell of urine. During an observation of Resident R24's room revealed blood on the restroom light switch, feces and blood on the bathroom floor and on the commode and sink. The overbed table was dirty, a large amount refuse on the floor, walls were unclean, and a wall outlet with a loose faceplate and a large gouge in the wall. Above the outlet was a handwritten sign that said Do Not Use This Outlet with an error pointing down toward the outlet. During an interview on 12/22/25, at approximately 2:20 p.m. the Environmental Services Supervisor Employee E5 confirmed that he currently only had three housekeepers currently employed. During an observation on 12/22/25, at 3:44 p.m., Resident R1 was noted to have a soiled brief on his restroom floor and what appeared to be feces on his bed linen. During an observation on 12/23/25, at 11:52 a.m., Resident R18's room had an overwhelming smell of urine. During an interview on 12/23/25, at 11:54 a.m., Nurse Aide Employee E4 stated that the urine was imbedded in the mattresses. During an observation on 12/23/25, at 11:58 a.m., Resident R22's room smelled of urine. During an observation on 12/23/25, at 12:08 p.m., Resident R23's room was unclean with soiled gloves on the overbed table. A bag of soiled linen was on the floor. During an electronic interview on 12/29/25, at 2:45 p.m., the Nursing Home Administrator confirmed that the facility failed to provide a clean and homelike environment on two of two nursing units and for seven of twelve residents. 28 Pa. Code: 207. 2(a) Administrator's responsibility. 28 Pa. Code: 201.29(k) Resident rights.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on review of facility documentation, clinical records, and staff interviews it was determined the facility failed to document and/or follow-up on concerns/grievances presented by staff and residents for five of five residents (Resident R11, R12, R13, R14, and R15).Findings include: Review of facility, Grievance Policy dated 6/1/25, indicated the facility is committed to maintaining transparent, fair, and accessible grievance process. Every grievance will be addressed promptly and appropriately, in accordance with federal and state regulations. Residents and their representative must be assured that: They can submit grievances orally or in writing; Their concerns will be investigated and responded to promptly; They will not face discrimination, reprisal, or retaliation; They will receive written notice of grievance outcomes within required timeframes. Review of a grievance filed by Resident R11 on 11/19/25, reported a concern related to not receiving showers. The form section that indicated if the resident/resident representative was informed of the resolution and the name of the person informed were blank. Review of a grievance filed by Resident R12 on 11/20/25, reported a concern related to not receiving showers. The form section that indicated if the resident/resident representative was informed of the resolution and the name of the person informed were blank. Review of a grievance filed by Resident R13 on 12/4/25, reported a concern related to not receiving fresh water. The form section that indicated if the resident/resident representative was informed of the resolution and the name of the person informed were blank. Review of a grievance filed on behalf of Resident R14 on 12/11/25, reported a concern related to Resident R14 being left in the wheelchair. The form section that indicated if the resident/resident representative was informed of the resolution and the name of the person informed were blank. Review of a grievance filed on behalf of Resident R15 on 12/17/25, reported a concern related to Resident R15 not receiving incontinence care. The form section that indicated if the resident/resident representative was informed of the resolution was blank and the name of the person informed was signed by the Director of Nursing. During an electronic interview on 12/29/25, at 2:45 p.m. the Nursing Home Administrator confirmed that the facility failed to document and/or follow-up on concerns/grievances presented by staff and residents for five of five residents. 28 Pa. Code 201.29(a) Resident Rights.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 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 review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to protect residents from verbal and emotional abuse and/or neglect for three of twelve residents (Resident R15, R23, and R25).Findings include: Review of the facility policy, Abuse and Neglect - Clinical Protocol dated 6/1/25, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish and neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Review of the clinical record indicated Resident R15 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 10/10/25, included diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and history of a stroke. Review of Section C: Cognitive Patterns indicated that Resident R15 was cognitively intact. Review of Section H: Bladder and Bowel indicated that Resident R15 was frequently incontinent of bladder and always incontinent of bowel. Review of Resident R15's plan of care for ADL (activities of daily living) self-care performance deficit initiated 7/22/24, indicated for staff to Assist with tasks as needed. Review of a progress note dated 12/17/25, at 9:38 a.m. indicated, LPN and CNA reported to this RN (Registered Nurse) that resident was very soiled this morning upon arrival for shift. This RN observed Pt in room (Resident R15's room). At time of assessment Pt (patient) was sitting on the edge of bed. Linen was visibly soiled with a yellow/brown saturated ring. Resident was still wearing depends brief which was heavily saturated and bulky. Resident stated he was not changed all night. Resident was cleaned up by nursing staff. Clean bed linen applied. Pts vital signs were stable. skin assessment completed. Buttocks and groin area appear red. Small scabbed area noted to toe. Skin otherwise intact.Review of Resident R15's ADL care record revealed the most recent incontinence care provided prior to the above incident was 12/18/25, at 8:20 p.m., with no care documented as needed. Previous care was documented by Nurse Aide (NA) Employee E8 on 12/16/25.Review of facility submitted information dated 12/17/25, indicated, [Resident R1] reported suspected neglect to [Licensed Practical Nurse (LPN) Employee E2]. The two suspected perpetrators were CNAs (nurse aides), NA Employee E6 and NA Employee E7. An immediate investigation was initiated. MD, family and APS were notified.Review of a resident statement dated 12/17/25, indicated, Upon interviewing the resident, the resident stated that he hadn't been changed since 11/16/25, at 2:00 p.m. The resident stated that he is left this way quite often and certain staff members do not want to change him. He stated that this was not the first time, but this time was really bad. Review of an undated employee statement written by NA Employee E8, indicated, [Resident R15] had light on at 7:30. I went into room to find [Resident R15] in deplorable conditions. Resident's bed was soiled w/poop and pee. When I stood resident up, resident's brief was soiled beyond what it should have been. Resident's brief was full of urine and poop to the point where it was running down his legs. Poop was all over resident's stomach and up his back. Upon taking resident into bathroom to wash him resident was asked by nurse when last time someone changed him. Resident said 2:00 p.m. yesterday afternoon 11/16/25 (12/16/25) so resident wasn't changed for 16 hours. That is when I changed him after lunch before I went home. This has been an ongoing thing. This has been reported on more than 1 occasion. Nothing has been done. Resident also stated I am the only one who changes him if I'm not here no one changes him. Resident had me crying and apologizing for the way he was left. He is always in that condition daily. Aides gone when I get here. Review of an employee statement written by LPN Employee E2, indicated, At 0715 I answered the resident's call light. Upon entering the room, I noticed a strong and foul odor coming from the resident. I informed the resident that I would inform his CNA that he needs attention. At 0730 [NA Employee E2] called me into resident's room. When I observed [Resident R15] in a extremely saturated brief that was so deplorable the front of the brief was brown. The resident's sheet on the bed had a large brown stain on it. I called the night and daylight supervisor to observe this. It was that bad! [Resident R15] stated that he had not been changed since 2 pm yesterday 12-16-25. The night supervisor stated the evening and nigh shift had adequate coverage. Review of the clinical record indicated Resident R23 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of dementia and history of a stroke. Review of Section C: Cognitive Patterns indicated that Resident R23 had moderate cognitive impairment. Review of Section H: Bladder and Bowel indicated that Resident R23 was always incontinent of bowel and bladder

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to implement policies and procedures to report possible neglect of one of three residents (Resident R23). Findings include: Review of facility policy Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigating dated 6/1/25, indicated The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility.The local/state ombudsman.The resident's representative. Adult protective services (where state law provides jurisdiction in long-term care).Law enforcement officials. The residents attending physician.The facility medical director. Immediately is defined as: Within two hours of an allegation involving abuse or result in serious bodily injury; or Within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Review of the clinical record indicated Resident R23 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 9/15/25, included diagnoses of dementia and history of a stroke. Review of Section C: Cognitive Patterns indicated that Resident R23 had moderate cognitive impairment. Review of Section H: Bladder and Bowel indicated that Resident R23 was always incontinent of bowel and bladder. Review of Resident R23's plan of care initiated 9/12/25, indicated that Resident R23 has episodes of incontinence related to impaired mobility and cognition. Review of Resident R23's ADL care record for incontinence care revealed the following:12/17/25: Documented as continent12/18/25: No bowel/bladder care provided. 12/19/25: No bowel/bladder care provided.12/20/25: No bowel/bladder care provided. Review of facility submitted information dated 12/22/25, indicated that Resident R23 had not been provided incontinence care multiple times. During an interview on 12/23/25, at 1:13 p.m. Therapy Employee E3 stated she had changed Resident R23's brief was changed by her on 12/18/25, at 10:00 a.m. Therapy Employee E3 stated she had labeled his briefs every day this week, and have found him to be extremely soiled, more than she would expect in one shift. At 10:00 a.m. on 12/19/25, Therapy Employee E3 stated that she discovered that he was still in the same brief, completely soiled. Resident R23's clothing and bedding were also beyond soiled, with a notable odor and yellow color. Therapy Employee E3 stated she brought this to the attention of the nurse supervisor, Administrator, Director of Rehabilitation, Social Services, and Human Resources. Review of documentation submitted by the facility to the State Survey Agency failed to include a report of possible neglect to Resident R23. During an electronic communication on 12/29/25, at 2:45 p.m. the Nursing Home Administrator confirmed the facility failed to implement policies and procedures to report possible neglect of one of three residents. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(e)(1) Management.28 Pa. Code 201.29(a) Resident rights.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa Code 211.12(d)(1)(2)(5) Nursing services.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interviews, it was determined that the facility failed to develop and implement a baseline care plan to include instructions needed to provide effective and person-centered care of the resident for ten of ten residents reviewed (Resident R1, R2, R3, R4, R5, R6, R7, R8, R9, and R10). Findings include: Review of the facility policy Care Plans, Comprehensive Person-Centered dated 6/1/25, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the residents physical, psychosocial, and functional needs is developed and implemented for each resident. Review of Resident R1's clinical record reviewed that the resident was admitted to the facility on [DATE]. Review of Resident R1's facility diagnosis list included Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior) and bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). Review of the clinical record for Resident R1 revealed the baseline care plan initiated 12/20/25, was incomplete on 12/23/25, three days after admission. Review of Resident R2's clinical record reviewed that the resident was admitted to the facility on [DATE]. Review of Resident R2's facility diagnosis list included dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and diabetes (a metabolic disorder in which the body has high sugar. Review of the clinical record for Resident R2 revealed the baseline care plan initiated 12/11/25, was incomplete on 12/23/25, 13 days after admission. Review of Resident R3's clinical record reviewed that the resident was admitted to the facility on [DATE]. Review of Resident R3's facility diagnosis list included spina bifida (birth defect where the spinal cord and backbones don't close completely, leaving an opening that can expose nerves) and bladder cancer. Review of the clinical record for Resident R3 revealed the baseline care plan initiated 12/8/25, was incomplete on 12/23/25, 18 days after admission. Review of Resident R4's clinical record reviewed that the resident was admitted to the facility on [DATE]. Review of Resident R4's facility diagnosis list included endocarditis (inflammation of the inner lining of the heart's chambers and valves) and atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat). Review of the clinical record for Resident R4 revealed the baseline care plan initiated 12/2/25, was incomplete on 12/23/25, 21 days after admission. Review of Resident R5's clinical record reviewed that the resident was admitted to the facility on [DATE]. Review of Resident R5's facility diagnosis list included encephalopathy (disease where brain function is affected by an agent or condition, such as viral infection or toxins in the blood) and diabetes. Review of the clinical record for Resident R5 revealed the baseline care plan initiated 12/10/25, was incomplete with errors on 12/23/25, 15 days after admission. Review of Resident R6's clinical record reviewed that the resident was admitted to the facility on [DATE]. Review of Resident R6's facility diagnosis list included dementia and chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness). Review of the clinical record for Resident R6 revealed the baseline care plan initiated 12/22/25, was incomplete on 12/23/25, four days after admission. Review of Resident R7's clinical record reviewed that the resident was admitted to the facility on [DATE]. Review of Resident R7's facility diagnosis list included wedge fraction (fracture where the front of the vertebra collapses) and prostate cancer. Review of the clinical record for Resident R7 revealed the baseline care plan initiated 12/22/25, was incomplete on 12/23/25, four days after admission. Review of Resident R8's clinical record reviewed that the resident was admitted to the facility on [DATE]. Review of Resident R8's facility diagnosis list included heart failure (a progressive heart disease that affects pumping action of the heart muscles) and diabetes. Review of the clinical record for Resident R8 revealed the baseline care plan initiated 12/16/25, was incomplete with errors on 12/23/25, eight days after admission. Review of Resident R9's clinical record reviewed that the resident was admitted to the facility on [DATE]. Review of Resident R9's facility diagnosis list included heart failure and COPD. Review of the clinical record for Resident R9 revealed the baseline care plan initiated 12/11/25, was incomplete on 12/23/25, 12 days after admission. Review of Resident R10's clinical record reviewed that the resident was admitted to the facility on [DATE]. Review of Resident R10's facility diagnosis list included throat cancer and COPD. Review of the clinical record for Resident R10 revealed the baseline care plan initiated 12/20/25, was incomplete on 12/23/25, four days after admission. During an electronic interview on 12/29/25, at 2:45 p.m., the Nursing Home Administrator confirmed the facility failed to develop and implement a baseline care plan to include instructions needed to provide effective and person-centered care of the resident for ten of ten residents

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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)

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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 observations and resident and staff interviews, it was it was determined that the facility failed to follow physician's orders for four of five residents (Resident R16, R17, R18, and R19).Findings include:Review of Resident R16's admission record indicated she was admitted to the facility on [DATE].Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 9/30/25, included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles) and hemiplegia (paralysis on one side of the body).Review of an active physician order dated 4/3/24, indicated Resident R16 should have a left protective sleeve and left resting hand splint, to be worn every day, day shift, as tolerated. Review of an active physician order dated 10/29/24, indicated Resident R16 should have a left an Isotoner glove to her left hand daily.Review of Resident R16's plan of care for self-care deficit and skin integrity last reviewed on 10/8/25, both indicated Resident R16 should have a left protective sleeve and left resting hand splint, to be worn every day, day shift, as tolerated.During observations completed on 12/23/25, between approximately 11:30 a.m. and 12:30 p.m., Resident R16 was observed in her room, without her protective sleeve, splint, or Isotoner glove on.Review of Resident R16's December 2025 treatment administration record (TAR) revealed that Licensed Practical Nurse (LPN) Employee E1 documented that Resident R16's sleeve, splint, or Isotoner glove was applied.Review of Resident R17's admission record indicated she was admitted to the facility on [DATE].Review of the MDS dated [DATE], included diagnoses of heart failure and hemiplegia.Review of an active physician order dated 8/31/22, indicated Resident R17 should have a right comfy grip hand orthosis to be worn, to be worn every day, day shift, as tolerated.Review of Resident R17's plan of care for self-care deficit last reviewed on 10/16/25, indicated Resident R17 should have a right comfy grip hand orthosis to be worn, to be worn every day, day shift, as tolerated.During observations completed on 12/23/25, between approximately 11:30 a.m. and 12:30 p.m., Resident R17 was observed in her room, without right hand orthosis on.Review of Resident R17's December 2025 TAR revealed that LPN Employee E1 documented that Resident R17's right hand orthosis was applied.Review of Resident R18's admission record indicated she was admitted to the facility on [DATE].Review of the MDS dated [DATE], included diagnoses of multiple sclerosis (a disease that affects central nervous system) and a seizure disorder. Review of an active physician order dated 9/21/22, indicated Resident R18 should have a left knee comfy splint to be worn, to be worn every day, day shift, as tolerated.Review of Resident R18's plan of care for self-care deficit last reviewed on 11/21/25, indicated Resident R18 should have a left knee comfy splint to be worn for four hours daily on day shift, as tolerated.During observations completed on 12/23/25, between approximately 11:30 a.m. and 12:30 p.m., Resident R18 was observed in her room, without the left knee splint on. Review of Resident R18's December 2025 TAR revealed that LPN Employee E1 documented that Resident R18's left knee splint was applied. Review of Resident R19's admission record indicated she was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of hemiplegia and high blood pressure. Review of an active physician order dated 6/23/23, indicated Resident R19 should have a right-hand roll to be worn, to be worn every day, day shift, as tolerated. Review of an active physician order dated 12/8/23, indicated Resident R19 should have a right-hand splint to be worn during the day shift, and removed at the end of day shift. Review of Resident R19's plan of care for self-care deficit last reviewed on 11/2/25, indicated Resident R19 should have a left knee comfy splint to be worn for four hours daily on day shift, as tolerated. During observations completed on 12/23/25, between approximately 11:30 a.m. and 12:30 p.m., Resident R19 was observed in his room, without the elbow splint or hand roll on. Review of Resident R19's December 2025 TAR revealed that LPN Employee E2 documented that Resident R19's left knee splint was applied. During an interview on 12/23/25, at approximately 1:15 p.m. Therapy Employee E3 stated that residents not having their splints and braces applied is a large concern and stated that often they don't get applied unless therapy staff to apply them. During an electronic interview on 12/29/25, at 2:45 p.m. the Nursing Home Administrator confirmed that the facility failed to follow physicians' orders for four of five residents. 28 Pa. Code 211.12(d)(1)(5) Nursing services.28 Pa. Code 211.12(d)(3) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395670	A. Building B. Wing	12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wecare at Monroeville Rehabilitation and Nsg Ctr	4142 Monroeville Blvd 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on review of facility policy, resident observations, resident and staff interviews, information submitted to the Pennsylvania Department of Health (PADOH, Resident Council minutes, 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 35 residents (Residents R1, R5, R11, R12, R13, R14, R15, R16, R17, R20, R22, R26, R27, R30, R31, and R32).Findings Include: Review of the facility policy, Answering the Call Light dated 6/1/25, indicated, The purpose of this procedure is to ensure timely responses to the resident's requests and needs. Review of the facility policy, Activities of Daily Living, (ADL), Supporting dated 6/1/25, indicated, 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. During an observation on 12/22/25, at approximately 1:19 p.m. Resident R1 was noted to be in dirty socks, wearing only a gown hanging off his shoulders, with foul-smelling breath and body odor. Resident R1 had an unkempt beard, and when asked he stated, I had to get all this stuff of me gesturing to his beard. During an interview and observation on 12/22/25, at approximately 1:25 p. m. Resident R13 stated that the facility is grossly understaffed. Today I had to take a poop. I had the misfortune of having to poop at 6:30 (a.m.). This means shift change at 7:00 (a.m.). I told the aide I needed changed at 7:55 (a.m.), she said, As soon as we pass the trays I will get you changed. Resident R13 stated that he put his call light on again as trays should have been passed by now. I sat in my own poop from 6:30 - 9:00. When asked about receiving showers, Resident R13 stated, They told me my shower day was Monday and Thursday. If I don't say something, I don't get it. During an observation on 12/22/25, at approximately 1:50 p.m. Resident R20 was noted to be wearing a gown with a wet brief on. Resident R20 was noted to be malodorous. Review of Resident R20 point of care documentation revealed the most recent incontinence care provided before the observation was 12/21/25, at 9:13 p.m. During an observation on 12/22/25, at approximately 3:45 p.m. Resident R1 was noted to be dressed in only a gown, with feces smeared on the bed linen. Observation at this time revealed Resident R1's lunch tray to be on the overbed table, without any portion eaten. Review of Resident R1's point of care documentation failed to reveal documentation of the amount eaten for 12/21/25 (breakfast, lunch), 12/22/25 (breakfast, lunch, dinner), 12/23/25 (breakfast, lunch, dinner), 12/24/25 (breakfast, lunch), 12/25/25 (lunch). During an observation on 12/23/25, at 11:45 a.m. Resident R15 was noted to have long, unclean fingernails, and he was noted to be malodorous. During an interview on 12/23/25, at 11:47 a.m. Resident R16, when asked if the facility maintains enough staff to care for the residents stated, No and began to laugh. When asked if she receives showers, stated that she prefers not to have showers, but would like to be actually washed when she receives bed baths. During an interview on 12/23/25, at 11:51 a.m. Resident R27, when asked if the facility maintains enough staff to care for the residents stated, No!. When asked if she receives showers, stated that she has to ask for showers, but still does not get them. During an observation on 12/23/25, at 11:53 a.m. Resident R17 was noted to have facial hair. Resident R17 was unable to be asked, as she is nonverbal. During an observation on 12/23/25, at 11:58 a.m. Resident R22 was noted to smell of urine. During an interview on 12/23/25, at 12:00 p.m. Resident R30, when asked if the facility maintained sufficient staff stated, Don't get me started on that. During an interview on 12/23/25, at 12:08 p.m. family for Resident R1 stated that they had concerns about the care provided to Resident R1. During an observation on 12/23/25, at approximately 12:10 p.m. of the 100-Unit nurses' station call light display monitor revealed:Resident R14's room had been alarming for 50 minutes.Resident R31's room had been alarming for 47 minutes.Resident R32's room had been alarming for 22 minutes.Resident R5's room had been alarming for 19 minutes.Resident R14's room had been alarming for 50 minutes. During an interview and observation on 12/23/25, at 12:50 p.m. Resident R26, when asked if the facility maintains enough staff to care for the residents stated, Heck no. Observation at this time revealed that Resident R26's hair was unbrushed and she remained in a gown at this time. During an interview on 12/23/25, at 1:08 p.m. Therapy Employee E12 stated that when meeting with residents, they appear to not have been provided personal care and are unclean and that residents are not being assisted to get out of bed. During an interview on 12/23/25, at 1:10 p.m. Therapy Employee E13 stated that when meeting with residents, residents have been in soiled briefs and appear unclean. Therapy Employee E13 stated it does not appear that residents are being assisted to bathe and are malodorous. Therapy Employee E13 stated that the facility is understaffed in nurses and nurse aides. During an interview on 12/23/25, at 1:13 p.m.

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	395670	A. Building B. Wing	12/29/2025

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review, and resident and staff interview it was determined the facility failed to obtain laboratory services as ordered for one of three residents (Resident R13).Findings Include: Review of the facility policy, Laboratory Testing and Result Management dated 6/1/25, indicated, The facility shall ensure that laboratory tests are obtained, processed., reviewed, and acted upon in a timely manner by qualified staff. Review of the clinical record revealed that Resident R13 was admitted to the facility on [DATE]. Review of Resident R13's Minimum Data Set (MDS, periodic assessment of resident care needs) dated 12/1/25, included diagnoses of chronic kidney disease (gradual loss of -kidney function), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and high blood pressure. Review of the plan of care dated 4/8/25, included a care of plan for psoriasis (a chronic skin condition that causes red, itchy, scaly patches). Review of dermatologist consultation report dated 12/10/25, indicated that Resident R13's psoriasis is uncontrolled by topical medications, and he required a systemic medication. The consultation report further stated, Blood work was also ordered today, he needs the labs completed prior to starting the medication. Review of Resident R13's progress notes failed to reveal any notes dated 12/10/25, through 12/14/25. Review of a progress note dated 12/15/25, at 2:00 p.m. indicated, Resident asking staff about bloodwork, culture of right knee, and x-ray of right knee. This nurse asks RN (registered nurse) to see if any such orders exist and RN couldn't locate any orders. RN supervisor went and spoke with resident regarding this situation. Review of a progress note dated 12/16/25, at 2:42 p.m. indicated staff from the dermatology office called and stated that labs were ordered and must be completed prior to starting the medication. Review of a physician's order dated 12/16/25, indicated the laboratory orders of :Hepatic function 2000 panel (liver function panel)Hepatitis B virus surface Ab (tests immunity to Hepatitis B virus)Hepatitis C (tests immunity to Hepatitis C virus)Mycobacterium tuberculosis tuberculin stimulated gamma interferon (test used to detect TB infection). The order was active for three days (12/18/25 - 12/21/25). Review of a progress note dated 12/25/25, at 1:50 p.m. indicated, Lab work drawn on 12/18/25. Further review of laboratory results and order confirmed that the lab work completed on 12/18/25, revealed that the blood tests were drawn related to an unrelated laboratory order. Review of the clinical record failed to reveal documentation that the blood tests were completed. During an interview on 12/22/25, at 12:59 p.m. the Nursing Home Administrator confirmed that the blood tests were not completed. During an interview on 12/23/25, at 1:34 p.m. Resident R13 confirmed that that the blood tests were not yet completed. During a review on 12/29/25, at 2:00 p.m. Resident R13 confirmed that that the blood tests were not yet completed. During an electronic interview on 12/29/25, at 2:45 p.m. the Nursing Home Administrator confirmed that the facility failed to obtain laboratory services as ordered for one of three residents. 28 Pa. Code: 201.14(a)(c) Responsibility of licensee.28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.