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	02/27/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record review and staff and resident interviews, it was determined that the facility failed to provide prescribed treatment and services related to the care of wounds for two of five residents (Resident R4 and R5).Findings include: Review of the PICO 14 Single Use Negative Pressure Wound Therapy (NPWT) System (device used for wound healing) directions for use indicated that the portable pump is connected to the absorbent adhesive dressing. The dressings have a wear time of up to seven days depending on the amount of fluid from the wound, and the pump has a battery life of 14 days. Review of Resident R4's admission record indicated he was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 2/3/26, included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles) and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) with the presence of a foot ulcer. Review of hospital documentation dated 1/29/26, indicated Resident R4 had a diabetic foot ulcer that developed osteomyelitis (inflammation of bone or bone marrow, usually due to infection), had debridement of the wound, implementation of antibiotic beads, and was ordered a wound vac (vacuum-assisted closure, a portable, battery-powered medical device used for negative pressure wound therapy (NPWT) to accelerate healing in acute, chronic, or severe wounds). Review of Resident R4's physician's orders indicated that Resident R4 did not have an active order for a wound vac until 2/13/26. Review of Resident R4's plan of care for diabetic ulcers initiated 2/1/26, failed to include information regarding the need for a wound vac. Review of Resident R4's progress notes revealed:-2/2/26: Physician, Assessment and Plan: L foot w/ implantation of antibiotic beads and wound VAC; F/U with Podiatry as directed.-2/2/26: Wound Nurse Practitioner, left midfoot diabetic foot ulcer (that had the antibiotic beadsplaced) (per hospital record should have a wound vac placed?). Gain Clarity if patient should have a wound vac.-2/2/26: Nurse Practitioner, Assessment and Plan: L foot w/ implantation of antibiotic beads and wound VAC; F/U with Podiatry as directed.-2/9/26: Wound Nurse Practitioner, There was question if left foot should have vac in place per their recommendations. Facility to clarify. ASSESSMENT/PLAN: Please clarify if Podiatry would like wound vac to left foot.-2/16/26: Physician's Assistant, Patient questioning wound VAC delivery.-2/16/26: Wound Nurse Practitioner, Patient seen by podiatry 2/9 still recommend wound vac to left foot, staff continues to work on obtaining. Podiatry would like wound vac to left foot- continue to obtain. Review of facility provided electronic documentation revealed:-Previous sister facility on 1/23/26, at 4:26 p.m. Wound vac arrived and is malfunctioning. We called the customer service number. They said to order another one.-Business Office Manager (BOM) on 1/30/26, at 1:32 p.m. (Registered Nurse Employee E1) has the wound vac, she will reach out to you to troubleshoot.-RN Employee E1 on 1/30/26, at 1:21 p.m. The patient was supposed to have an appointment with his podiatry today, but it had to be rescheduled due to transportation issues.-Regional Director on 1/30/26, at 1:23 p.m. Where is the wound vac, (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I will get a label so we can return the wound vac.-Regional Director on 1/30/26, at 1:32 p.m. RN Employee E1 has the wound vac, she will reach out to you.-Regional Director on 1/30/26, at 2:08 p.m. There were 2 at that facility, one was working and one needed service.-Regional Director on 2/2/26, at 1:11 p.m. Please update me on the status of our resident that was admitted to the facility that was supposed to get the wound vac.-Regional Director on 2/2/26, at 1:33 p.m. Please send a return label to (facility) to return (Resident R4's) wound vac.-BOM on 2/3/26, at 2:42 p.m. When did he start/stop the pump at (facility)? No one put it in the system.-Regional Director on 2/3/26, at 2:47 p.m. They never started it at (facility).-Regional Director on 2/4/26, at 6:58 a.m. Please print this label and place the wound vac in the box and return. There should be a plastic black box, a fabric holder for the wound vac itself. If someone can confirm when the building has left, that would be appreciated.-Regional Director on 2/12/26, at 5:37 p.m. The wound vac air tag is still in (facility) which means the pump is still there. We need to find the pump. I sent the sticker to send back. Was told it went back.-Regional Director on 2/13/26, at 6:15 p.m. The wound vac was located. There were supplies delivered for that resident on January 23 of 2026. I did ask that we try to wound vac on the resident if we can locate those supplies. Please provide an update. We also have another one coming your way on Monday thank you. Review of a grievance submitted to the facility by Resident R4 on 2/18/26, indicated:Summary of Complaint: Resident R4 had, No wound vac since admission on [DATE].Steps taken to investigate: Upon arrival supplies for the wound vac were in house. The wound vac that was delivered wasn't properly functioning. Svc call placed to company to troubleshoot. Determined that wound vac would need to be replaced. Order changed to wet/dry dressing throughout his stay.Summary of Findings: No wound vac present but orders changed and wound care followed.Corrective action: Communicated updates to the residents re: wound vac status. Kept him informed about the progress of his wounds. Reviewed the wound from (wound care provider). Verbalized that he was pleased with the progress of his wound healing. During an interview on 2/24/26, at 12:19 p.m. Resident R4 confirmed that he never received a wound vac during his stay at the facility, stated that he was unhappy with his wound care and never would have stated that he was pleased with the progress of his wound healing. When asked if the facility kept him informed about the progress of his wounds, Resident R4 stated That is a crock of shit and stated while his wound did not deteriorate further, there was negligible improvement either. Resident R4 stated that he did not always receive his wound care as scheduled and many times had to request to have his scheduled dressing changes completed. Review of Resident R4's Treatment Administration Record (TAR) from 2/1/26, through 2/17/26, indicated the following orders:Wet to dry (in place of wound vac) care had no documentation on 2/1/26 night shift, 2/8/26 evening shift, 2/10/26 day shift, 2/14/26 evening shift, 2/15/26 day shift, 2/16/26 evening shift, 2/17/26 evening shift.Petrolatum gauze to right plantar foot had no documentation on 2/10/26, 2/15/26.Left mid foot wound care had no documentation on 2/10/26, 2/15/26.Left posterior thigh pressure wound care had no documentation on 2/10/26, 2/15/26.Right mid foot wound care had no documentation on 2/10/26, 2/15/26.Right shin wound care had no documentation on 2/10/26, 2/15/26.Xeroform to right medial lower leg wound care had no documentation on 2/10/26, 2/15/26. Review of Resident R5's admission record indicated she was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of bacteremia (presence of bacteria in the bloodstream), high blood pressure, and history of a stroke. Review of a physician order dated 2/1/26, indicated PICO 14 Negative Pressure Wound therapy dressing to Left femoral region per protocol. Monitor to ensure proper function and intact Seal. Reinforce dressing as needed. Review of Resident R5's plan of care for actual skin impairment initiated 2/1/26, failed to include goal or interventions for the use of a PICO dressing. Review of Resident R5's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hospital discharge paperwork dated 1/31/26, indicated Resident R5's PICO 14 dressing was placed on 1/26/26. Review of a progress note dated 2/1/26, at 1:28 a.m. indicated, (Negative Pressure dressing [NAME] and Nephew (manufacturer) PICO 14 On, not to be touched). Review of a wound nurse practitioner note dated 2/3/26, at 10:09 p.m. indicated, PICO (negative pressure system) intact to left groin. not removed (7 day life, battery pack in place). Review of a wound nurse practitioner note dated 2/9/26, at 1:36 p.m. indicated, PICO (negative pressure system) intact to left groin. not removed (7 day life, battery pack in place), replace at day 7 or 3/4, saturated dressing then at that time replace dressing only conserve battery pack until battery pack turns off. Review of a wound nurse practitioner note dated 2/16/26, at 2:35 p.m. indicated, PICO battery is dead, PICO dressing removed. Further review of Resident R4's clinical record failed to reveal documentation that the dressing portion of Resident R4's PICO dressing was changed after seven days (2/2/26, 2/9/26, 2/15/26) and that the battery pack was changed after 14 days (2/9/26). During an interview on 3/29/24, at approximately 1:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide prescribed treatment and services related to the care of wounds for two of five residents 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 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 facility policy review, clinical and facility record review, facility submitted documents, and staff interviews, it was determined that the facility failed to provide adequate supervision to prevent elopement for one of five residents (Resident R1). This was identified as past non-compliance.Findings include: Review of the facility policy Wandering and Elopements dated 1/8/26, indicated the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining he lest restrictive environment for residents. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2025, indicated that a Brief Interview for Mental Status (BIMS), is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of the clinical record revealed Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 12/15/25, included diagnoses of atherosclerotic heart disease (build-up of fats, cholesterol, and other substances in and on the artery walls), age-related debility, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Section C: Cognitive Patterns indicated Resident R1 had a BIMS score of 8. Review of an Elopement Risk Evaluation completed on 11/22/25, at 5:47 p.m. indicated Resident R1 was at risk for elopement. Review of Resident R1's plan of care for At risk for elopement initiated 1/11/25, indicated, Will remain safe within facility unless accompanied by staff or other authorized person. Review of a physician's order dated 7/9/25, indicated for staff to monitor Resident R1's wandering behavior. Review of facility submitted information submitted 2/12/26, indicated that on 2/10/26, at 5:30 p.m. [Resident R1] was identified by staff to have wandered out of the facility. The resident was immediately recovered by staff and redirected back into the facility. The resident was last seen at 1718 (5:18 p.m.) by a CNA (nurse aide). The resident was brought back into the building at 1720 by an LPN (licensed practical nurse) who sighted the resident outside of the building. The resident was wearing a long sleeve shirt with pants and a pair of loafer shoes. The temperature outside was 50 degrees Fahrenheit on that day. Review of a progress note dated 2/10/26, at 8:12 p.m. indicated, Resident was discovered to have walked outside of the building via the back door on the 200s side. The door opened easily and low alarm rang, but not the loud alarm - it remained silent. Review of an employee statement written by Nurse Aide (NA)Employee E1, dated 3/17/24, indicated, On 3/11 shift, I was walking out of a resident's room after changing them, when I seen a guy walk out of another residents room who I never recognized being down that hallway to begin with so I was under the assumption that it was a residents family member. He ended up walking to the Exit doors trying to get out, not recognizing the alarm on his ankle nor did any alarms go off as he exited the building. About ten minutes after him leaving the building is when the alarms on side 2 start going off as he came back into the facility. On 2/10/26, the facility initiated a plan of correction that included:-Resident assessment to ensure no injuries.-Notification of resident representative and medical provider. -Checks every 15 minutes on Resident R1.-Immediate head count of all residents in the facility.-Immediate functionality checks on exit doors and alarms.-A whole house audit of all residents with updated elopement assessments completed for each resident.-Facility-wide reeducation was completed with all staff on policies and procedures related to elopement.-Daily head counts completed by the Director of Nursing or Designee to ensure residents are accounted for.-Door alarm functionality audits completed twice per shift. -Daily door alarm checks for all facility exit doors. -Audits to be forward to the monthly Quality Assurance and Performance Improvement (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Committee for review. The facility was back in compliance on that date. Interviews with five licensed nursing staff on 2/24/26, confirmed they received education on elopement prevention and procedures if an elopement occurs. Nurses were able to demonstrate alarm door functionality. During an interview on 3/29/24, at approximately 1:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide adequate supervision to prevent elopement for one of seven residents, that was determined to be past noncompliance. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(e)(1) Management.28 Pa. Code 201.20(b)(1) Staff Development.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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, resident interviews and observations, staff interviews, and it was determined that the facility failed to provide appropriate respiratory care for two of four residents (Resident R2 and R3). Findings include: Review of facility policy Administering Medications 1/8/26, indicated medications are administered in a safe and timely manner, and as prescribed. The policy further stated that the individual administering the medication records in the resident's medical record:-the date and time the medication was administered;-the dosage;-the route of administration;-the injection site (if applicable);-any complaints or symptoms for which the drug was administered;-any results achieved and when those results were observed; and-the signature and title of the person administering the drug. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2025, indicated that a Brief Interview for Mental Status (BIMS), is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 1/23/26, included diagnoses of atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat) and chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness). MDS Section C: Cognitive Patterns indicated Resident R2 had a BIMS score of 15. Review of Resident R3's plan of care for shortness of breath related to Flu A (influenza type A) and COPD initiated 1/20/26, failed to include the use of respiratory medications or nebulizer treatments. Review of a physician's active orders dated 1/20/26, Resident R2 is to receive a Breo Ellipta (a once-daily, dry-powder maintenance inhaler used to control symptoms of COPD). The order was further documented that a therapeutic interchange was completed, and Resident R2 was to receive Ipratropium-Albuterol 0.5-2.5 (3) MG/3ML Solution, Inhale the contents of 1 ampule via nebulizer every 8 hours. Review of Resident R2's Medication Administration Record (MAR) for the use of the Breo Ellipta from 2/1/26, through 2/24/26, indicated the following:2/01/26: Received2/02/26: Held by nurse2/03/26: Received2/04/26: Received2/05/26: Received2/06/26: Received2/07/26: Received2/08/26: Received2/09/26: Held by nurse2/10/26: Received2/11/26: Held by nurse2/12/26: Received2/13/26: Held by nurse2/14/26: Received2/15/26: Received2/16/26: Received2/17/26: Held by nurse2/18/26: Held by nurse2/19/26: Received2/20/26: Received2/21/26: Received2/22/26: Undocumented2/23/26: Received2/24/26: Received Further review of Resident R2's MAR revealed no information and timing were available to document the use of Ipratropium-Albuterol three times daily, in place of the once daily Breo Ellipta. Resident R3 was unavailable for interview at this time. During an interview 2/24/26, at approximately 1:45 p.m. Resident R2 confirmed that he has not been receiving his Breo Ellipta inhaler. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of the MDS needs dated 2/3/26, included diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels) and COPD. MDS Section C: Cognitive Patterns indicated Resident R3 had a BIMS score of 14. Review of Resident R3's plan of care for shortness of breath initiated 2/1/26, failed to include the use of respiratory medications or nebulizer treatments. Review of a physician's active orders dated 1/30/26, Resident R3 is to receive a Trelegy Ellipta (a once-daily, dry-powder maintenance inhaler used to treat COPD). Review of a physician's active orders dated 1/30/26, Resident R3 is to receive Ipratropium-Albuterol Inhalation Aerosol Solution 20-100 MCG/ACT, one inhalation every six hours as needed for COPD. The order was documented that supplied by the pharmacy was Ipratropium-Albuterol 0.5-2.5 (3) MG/3ML Solution, Inhale the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contents of 1 ampule via nebulizer every 6 hours as needed for COPD, Review of Resident R3's Medication Administration Record (MAR) for the use of the Trelegy Ellipta from 2/1/26, through 2/24/26, indicated the following:2/01/26: Received2/02/26: Received2/03/26: Received2/04/26: Held by nurse2/05/26: Received2/06/26: Received2/07/26: Received2/08/26: Received2/09/26: Held by nurse2/10/26: Received2/11/26: Held by nurse2/12/26: Received2/13/26: Held by nurse2/14/26: Received2/15/26: Received2/16/26: Received2/17/26: Held by nurse2/18/26: Held by nurse2/19/26: Received2/20/26: Received2/21/26: Received2/22/26: Undocumented2/23/26: Received2/24/26: Received During an observation on 2/24/26, at approximately 1:50 p.m. of the 100-unit hall medication cart, Resident R2's Breo Ellipta inhaler and Resident R3's Trelegy Ellipta inhaler were not present in the medication cart. Both resident had pharmacy supplied boxes of Ipratropium-Albuterol 0.5-2.5 ampules present, with the notation on the pharmacy label as therapeutic interchange. Both boxes appeared unused, and when opened had the full supply of ampules present. During an interview on 2/24/26, at approximately 1:52 p.m. Licensed Practical Nurse (LPN) Employee E1 confirmed that Resident R2 and R3's inhalers were not present in the medication cart and confirmed that no Ipratropium-Albuterol ampules had been removed from the boxes in the medication cart. When asked why both Resident R2 and Resident R3 had documentation in their MARs that they received their inhalers during the 9:00 a.m. med pass earlier in the day, LPN Employee E1 was unable to provide an answer. During an observation on 2/24/26, at approximately 2:10 p.m., upon entering the shared room of Resident R2 and R3, both residents were observed to be having a nebulizer treatment. Interviews at this time confirmed that neither resident had ever received prior nebulizer treatments while in the facility, and Resident R3 confirmed that he has not been receiving his Trelegy Ellipta inhaler. During an interview on 2/24/26, at 2:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide appropriate respiratory care for two of four residents. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on facility documents, observations, and staff interviews, it was determined that the facility failed to make certain door alarm systems were regularly tested for functionality. Findings include: Review of the facility Maintenance Manager job description indicated the Maintenance Manager Maintains competency & is tested to be competent in:Machine Maintenance requirementsFire Prevention & SafetyInfection Control/OSHA & CDCFacility Maintenance requirements Review of the facility alarm testing instructions stated:Check delayed egress operation (if applicable)1. Push door release hard for a fraction of a second - door should not open and alarm shouldnot sound2. Apply pressure to the door release for the pre-determined nuisance period setting (normally1-3 seconds)3 Door should go into irreversible unlocking sequenceDoor alarm will soundDoor will automatically open within (15-30 seconds)4 Close door and reset the alarm5 Ensure signs are placed on doors adjacent to the release device that read 'Push until alarmsounds. Door can be opened in 15 seconds.6 Confirm that security panels at Nurse Station activate when door is opened and that itproperly indicates the location of the door released.7 Door keypad battery shall be replaced annually, if applicable. During an interview on 2/23/26, at approximately 11:00 a.m. the Maintenance Director and surveyor attempted to check door alarm functionality. Maintenance Director was unaware how to deactivate the alarm. Nursing staff were required to respond to the alarming door to silence the alarm and reactivate the door locking mechanism. When asked how he ensures the door alarms are functional, Maintenance Director stated he checks the door by attempting to open it to ensure that it is locked. At this time, the Maintenance Director confirmed that action only ensures the door is locked, but does not verify functionality of the alarm. During an interview on 9/19/25, at 1:01 p.m. Nursing Home Administrator confirmed that the facility failed to make certain door alarm systems were regularly tested for functionality. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management.