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	06/28/2024

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** 43725 Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to notify physicians of increased and decreased Capillary Blood Glucose (CBG) levels and failed to assess residents for hyperglycemia (high blood glucose) and hypoglycemia (low blood glucose), for 8 of 19 Residents (Residents R3, R9, R54, R55, R59, R61, R66, R187). Findings: Review of the clinical record revealed Resident R3 was admitted to the facility on [DATE], with diagnoses that included diabetes, high blood pressure, and depression. Review of the Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 5/6/24, indicated the diagnoses remain current. Review of a physician order dated 10/12/23, revealed Novolog (fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) insulin, 8 units three times a day. On 4/10/24, Lantus (long-acting type of insulin that works slowly, over about 24 hours), 5 units once daily. Review of the clinical record electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: On 1/8/24, at 9:43 p.m. CBG was noted to be 430. On 4/16/24, at 9:02 p.m. CBG was noted to be 409. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, the blood glucose was not monitored for effectiveness of treatment, failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed dates. Review of the care plan dated 5/2/23, included diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, monitor/document/report to MD as needed for signs and symptoms of hypo-/hyperglycemia. (continued on next page)

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	Review of the clinical record revealed Resident R9 was admitted to the facility on [DATE], with diagnoses that included diabetes, high blood pressure, and stroke. Review of the Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 5/7/24, indicated the diagnoses remain current. Review of a physician order dated 5/23/24, revealed Humalog insulin, 14 units three times a day, hold if meal will be missed. A physician order dated 5/22/24, revealed Lantus 24 units twice daily. Review of the clinical record electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: On 3/5/24, at 4:16 p.m. CBG was noted to be 410. On 4/19/24, at 8:37 p.m. CBG was noted to be 449. On 4/23/24, at 6:23 a.m. CBG was noted to be 450. On 5/15/24, at 4:26 p.m. CBG was noted to be 446. On 5/16/24, at 8:28 p.m. CBG was noted to be 411. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, the blood glucose was not monitored for effectiveness of treatment, failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed dates. Review of the care plan dated 5/19/24, included diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, monitor/document/report to MD as needed for signs and symptoms of hypo-/hyperglycemia. Review of the clinical record revealed Resident R54 was admitted to the facility on [DATE], with diagnoses that included diabetes, dementia (group of symptoms affecting memory, thinking and social abilities), and depression. Review of the MDS dated [DATE], indicated the diagnoses remain current. Review of a physician order dated 3/19/24, indicated to inject Novolog insulin per sliding scale, if over 400 give 12 units and call physician. Review of the clinical record electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: On 4/6/24, at 5:05 p.m. CBG was noted to be 412. On 4/25/24, at 4:52 p.m. CBG was noted to be 485. On 5/17/24, at 5:36 a.m. CBG was noted to be 416. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/17/25, at 8:08 a.m. CBG was noted to be 416. On 6/13/24, at 5:34 a.m. CBG was noted to be 419. On 6/21/24, at 5:46 a.m. CBG was noted to be 475. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, the blood glucose was not monitored for effectiveness of treatment, failed to follow interventions of the care plan, failed to follow physician ' s order, and the physician was not notified of abnormal results on the above listed dates. Review of the care plan dated 3/4/24, included diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, monitor/document/report to MD as needed signs and symptoms of hypo-/hyperglycemia. Review of the clinical record revealed Resident R55 was readmitted to the facility on [DATE], with diagnoses that included diabetes, high blood pressure, and anxiety. Review of the MDS dated [DATE], indicated the diagnoses remain current. Review of a physician order dated 7/20/23, instructed to inject Lispro (fast acting insulin) 10 units with meals. Review of the clinical record electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: On 1/3/24, at 5:42 a.m. CBG was noted to be 412. On 1/3/24, at 1:26 p.m. CBG was noted to be 455. On 1/11/24, at 11:41 p.m. CBG was noted to be 433. On 1/12/24, at 11:41 p.m. CBG was noted to be 407. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, the blood glucose was not monitored for effectiveness of treatment, failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed dates. Review of the care plan dated 7/11/19, included diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, monitor/document/report to MD as needed signs and symptoms of hypo-/hyperglycemia. Review of the clinical record revealed Resident R59 was admitted to the facility on [DATE], with diagnoses that included diabetes, high blood pressure, and depression. Review of the MDS dated [DATE], indicated the diagnoses remain current. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician order dated 12/29/23, instructed to inject Aspart (fast acting insulin) per sliding scale, if over 401 give 20 units and call the doctor. Review of the clinical record electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: On 1/31/24, at 4:22 p.m. CBG was noted to be 460. On 3/6/24, at 9:52 a.m. CBG was noted to be 415, confirmed at 9:58 a.m. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, the blood glucose was not monitored for effectiveness of treatment, failed to follow interventions of the care plan, failed to follow physician ' s order, and the physician was not notified of abnormal results on the above listed dates. Review of the care plan dated 1/18/24, included diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, monitor/document/report to MD as needed signs and symptoms of hypo-/hyperglycemia. Review of the clinical record revealed Resident R61 was admitted to the facility on [DATE], with diagnoses that included diabetes, high blood pressure, and repeated falls. Review of the Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 5/8/24, indicated the diagnoses remain current. Review of a physician order dated 6/10/24, revealed Lantus (long-acting type of insulin that works slowly, over about 24 hours), 8 units twice daily. Review of the clinical record electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: On 2/26/24, at 8:59 p.m. CBG was noted to be 431. On 5/24/24, at 4:34 a.m. CBG was noted to be 60. On 5/26/24, at 8:17 a.m. CBG was noted to be 69. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hyper-/hypoglycemia, the blood glucose was not monitored for effectiveness of treatment, failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed dates. Review of the care plan dated 4/18/24, included diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, monitor/document/report to MD as needed for signs and symptoms of hypo-/hyperglycemia. Review of the clinical record revealed Resident R66 was admitted to the facility on [DATE], with diagnoses that included diabetes, high blood pressure, dementia, and repeated falls. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 5/14/24, indicated the diagnoses remain current. Review of a physician order dated 5/23/24, revealed Humalog insulin, 6 units with meals and additional Humalog-Sliding scale ordered 4/22/24, (less than 70 initiate diabetic protocol and notify physician, greater than 400 give 18 units and notify physician). Review of physician order dated 5/1/24, Metformin (oral medication to help control the amount of glucose in your blood and increase your body ' s response to insulin), 500 mg twice daily. Review of the clinical record electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: On 4/29/24, at 11:33 a.m. CBG was noted to be 544. On 5/2/24, at 4:34 a.m. CBG was noted to be 430. On 5/17/24, at 4:52 p.m. CBG was noted to be 400. On 5/17/24, at 8:12 p.m. CBG was noted to be 441. On 6/14/24, at 12:22 p.m. CBG was noted to be 57. On 6/12/24, at 6:33 p.m. CBG was noted to be 70. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hyper/hypoglycemia, the blood glucose was not monitored for effectiveness of treatment, failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed dates. Review of the care plan dated 5/24/24, included diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, monitor/document/report to MD as needed for signs and symptoms of hypo-/hyperglycemia. Review of the clinical record revealed Resident R187 was admitted to the facility on [DATE], with diagnoses that included diabetes, high blood pressure, and depression. Review of a physician order dated 6/19/24, instructed to inject Lispro insulin per sliding scale, if over 401 give 10 units. Review of the clinical record electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: On 6/20/24, at 8:06 p.m. CBG was noted to be 424. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, the blood glucose was not monitored for effectiveness of treatment, failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed dates. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan dated 6/19/24, failed to include interventions for diabetes. During an interview on 6/26/24, at 8:10 a.m. Licensed Practical Nurse (LPN) Employee E1 stated for resident's without diabetic parameters they would notify the doctor for blood glucose levels under 100, or over 200. For a low fingerstick, they would start the facility protocol. For a high fingerstick, they would call the doctor, and document the incident everywhere I could in the medical chart. During an interview on 6/26/24, at 8:22 a.m. LPN Employee E2 stated for residents without ordered diabetic parameters they would notify the doctor if blood glucose was under 70, or over 250. They would follow facility protocol for low results, and if it was high, they would give the ordered insulin and call the doctor, and document in the progress notes and under the vital signs tab in the clinical record. During an interview on 6/26/24, at 8:24 a.m. LPN Employee E3 stated for residents without ordered parameters they would notify the doctor in blood glucose results were under 70, or over 300. If it was low, they would start the facility protocol, call the doctor and the RN (registered nurse) supervisor, and recheck the blood glucose in 15 minutes. They would document the incident in the progress notes and the eMAR. During an interview on 6/26/24, at 8:27 a.m. LPN Employee E4 stated they would notify the doctor is CBG was under 70, or over 160-190. If low, they would give a snack, or juice, and recheck in 15 minutes. If high, they would give the scheduled insulin and notify the doctor. They would document in the progress notes. During an interview on 6/26/24, at 8:32 a.m. LPN Employee E5 stated for diabetic resident's without an ordered parameter they would notify the doctor if blood glucose was under 70 or over 300. If low, they would offer juice or snack, if high, they would call the doctor. They would document in the progress notes, notify the RN supervisor, and pass it on in shift report. During an interview on 6/27/24, at 9:15 a.m. the Director of Nursing (DON) confirmed the facility failed to provide timely and complete communication to a physician when there was a change in condition. The DON confirmed the facility failed to recognize, assist and document the treatment of complications commonly associated with diabetes. Documentation should reflect the carefully assessed diabetic resident for vital signs, skin (color, temperature, dryness, sweating, irritation or abrasions), percentage of meals consumed, mood changes, pain, restlessness, numbness/tingling, results of any fingerstick, interventions to stabilize the blood glucose levels and response, notification of physician of unstable or significant variances from base line per physician order. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29(d) Resident rights 28 Pa. Code 211.10 (c)(d) Resident care policies 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49646 Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to make certain that medical supplies were properly stored and/or disposed of in one of two supply rooms (100-Unit supply room). Findings include: Review of the facility policy Storage of Medications dated 6/1/23, indicated medications are and biologicals are stored safely, securely, and properly, following manufacturer's recommendations. During an observation of the 100-Unit supply room on 6/27/24, at approximately 9:17 a.m. the following was observed: (6) boxes Shiley disposable inner trach cannulas, with expiration of 4/20/21 and 8/31/19. (2) boxes of wound irrigation trays, with expiration of 12/23. (6) boxes of 3ml syringes (100 count), with expiration of 10/18/23. (3) urethral catheter, with an expiration date of 6/28/23. (4) intravenous fluid administration sets, with an expiration date of 10/13/23. (1) box of mini-bore IV extension sets, with expiration of 10/30/23 (6 bags in box had prior resident's names). (1) box vacutainers, with an expiration date of 10/20/23. (6) boxes of luer locks, with an expiration date of 9/8/22. During an interview on 6/27/24, at 9:34 a.m. Employee E6 confirmed the above observation. During an interview on 6/27/24, at approximately 12:00 p.m. the Director of Nursing confirmed that the facility failed to make certain that medical supplies were properly stored in one of two supply rooms. 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management.