

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395698	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2026
NAME OF PROVIDER OR SUPPLIER Meadowcrest Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 Braun Road Bethel Park, PA 15102	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on review of employee qualification and staff interview it was determined that the facility failed to employ a qualified Food Service Director to manage the daily operations of the Dietary Department for 12 out of 12 months (April 2025 through March 2026). Findings include: During an interview on 3/4/26, at 9:40 a.m., the Dietary Supervisor stated she was not certified and that the Dietitian only works two days a week. During an interview on 3/4/26, at 10:00 a.m., the Nursing Home Administrator stated that the Registered Dietitian (RD) was not employed full time she comes two times a week. The RD was not on-site full time to oversee the operation of the kitchen in the absence of a full time qualified dietary manager. During an interview on 3/4/26, at 10:12 a.m., the Nursing Home Administrator (NHA) confirmed that the facility failed to provide documented evidence that Dietary Manager Employee E1 met the qualifications for the position of Food Service Director. Pa Code: 201.18(e)(6) Management.		

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on a review of facility policy, observations and staff interview it was determined that the facility failed to properly store food products in the Main Kitchen, which created the potential for foodborne illness in one of one deep freezer. Findings Include:Review of the facility policy Food Receiving and Storage dated 1/8/26, indicated that all food items will be received and stored in a manner that complies with safe food handling practices.During an observation of the main kitchen on 3/4/26, at 9:40 a.m., revealed food being stored directly under the fans of the deep freezer with ice buildup and approximately three inches from the ceiling of the deep freezer.During an interview on 3/4/26, at 9:43 a.m., the Dietary Supervisor Employee E10 confirmed that the facility failed to properly store food products in the Main Kitchen, which created the potential for foodborne illness.Pa. 28 Code: 211.6(c)(d)(f) Dietary services.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review facility policy, clinical records, observations, and resident and staff interviews, it was determined that the facility failed to ensure an environment free from the spread of infection for five of twelve residents (Residents R1, R4, R6, R12, and R33) and failed to implement an infection control program that included a system of surveillance to identify possible communicable diseases or infections for 12 of 12 months (April 2025 through March 2026). Findings include: Review of the clinical record indicated Resident R4 was admitted on [DATE]. Review of the facility policy Enhanced Barrier Precautions dated 1/8/26, previously dated 1/14/25, indicated, Enhanced barrier precautions (EBBs) are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Personal protective equipment (PPE) is changed before caring for another resident. Face protection may be used if there is also a risk of splash or spray. Review of the United States Food and Drug Administration prescribing information indicated, 0.9% Sodium Chloride Irrigation USP is utilized for a variety of clinical indications such as sterile irrigation of body cavities, tissues or wounds, indwelling urethral catheters, surgical drainage tubes, and for washing, rinsing or soaking surgical dressings, instruments and laboratory specimens. The guidance further stated that the sodium chloride solution should be discarded after 24 hours to prevent contamination. Review of Resident R4's Minimum Data Set (MDS-a periodic assessment of care needs) dated 2/19/26, indicated diagnoses of atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and osteomyelitis (inflammation of bone or bone marrow, usually due to infection). Review of a physician's order dated 2/13/26, indicated that Resident R4's wound vac dressing to be changed three times per week on Monday, Wednesday, and Friday on day shift. Review of a physician's order dated 2/16/26, indicated that Resident R4 was ordered enhanced barrier precautions related to a left foot wound. Review of Resident R4's care plan dated 2/12/26, indicated a plan of care developed for enhanced barrier precautions secondary to surgical wound. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation of wound care on 3/4/26, at approximately 3:00 p.m. Licensed Practical Nurse Employee E2 performed wound care without using a gown. Review of current physicians' orders on 3/5/26, revealed seven facility residents to be ordered Enhanced Barrier Precautions (Residents R1, R2, R4, R5, R6, R12, and R33). During an observation of the [NAME] and Garden nursing units on 3/5/26, beginning at approximately 11/10 a.m. the room for Residents R1, R4, R6, R12, and R33 did not have signage at the door indicating enhanced barrier precautions. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of paraplegia and neurogenic bladder. Review of Section C: Cognitive Patterns indicated that Resident R1 was cognitively intact. Review of Section M: Skin Conditions indicated the presence of a Stage Four pressure ulcer. Review of the plan of care dated 3/3/26, indicated that Resident R1 had actual skin impairment related to impaired mobility. Included in the interventions was, Administer treatment per physician order. Review of a physician's order dated 3/3/26, indicated that Resident R1 was to have dressing changes to sacral wound: Clean with acetic acid 1%, apply zinc oxide to peri wound, apply collagen, calcium alginate and apply ABD bid and prn. During a dressing change observation completed on 3/5/26, at 2:00 p.m. the following was observed: Sterile saline solution was opened and partially used. Resident R1 stated to surveyor, That shouldn't be opened. A clean barrier was not placed under the wound. Bedding under the wound was soiled with wound drainage. Bath towel used as a clean field on the overbed table. 4x4 gauze placed directly on the bath towel and saturated with normal saline solution. The soiled dressing removed was noted to be dated 3/3/26, without a documented time or staff member who performed the dressing change. Review of facility policy Infection Control Program dated 1/8/26, with a previous review date of 1/14/25, indicated the Infection Preventionist will conduct ongoing surveillance of Healthcare Associated Infections (HAI's) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission- based precautions and other preventive interventions. Review of the facility's Infection Control documentation for the previous 12 months (April 2025 -March 2026) failed to reveal surveillance for tracking infections for residents for 12 of 12 months (April 2025-March 2026). (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/6/26, at approximately 12:00 p.m. the Nursing Home Administrator confirmed the facility failed to ensure an environment free from the spread of infection for five of twelve residents and failed to implement an infection control program that included a system of surveillance to identify possible communicable diseases for April 2025 through March 2026. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(e)(1) Management.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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on review of the facility's infection control policies and procedures and staff interview, it was determined that the facility failed to implement an antibiotic stewardship program for 12 of 12 months (April 2025 -March 2026). Findings include:Review of facility policy Antibiotic Stewardship Program last reviewed 1/8/26, with a previous review date of 1/14/25, indicated the Antibiotic Stewardship will focus on monitoring the use of antibiotics, improving antibiotic use by avoiding unnecessary or inappropriate antibiotics. The antibiotic stewardship process will be overseen and managed by the Infection Preventionist who works collaboratively with the medical director, pharmacist, nursing and administrative leadership.Review of the facility's Infection Control surveillance for April 2025- March 2026, failed to include documentation to indicate that antibiotic monitoring was completed.During an interview on 4/6/26, at 12:00 p.m., the Nursing Home Administrator confirmed that the facility failed to implement an antibiotic stewardship program for 12 of 12 months (April 2025-March 2026).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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility policy, and staff interview, it was determined that the facility failed to ensure that resident's medication regime was free from unnecessary psychotropic (substances that act on the brain to alter cognition, perception, and mood) medication for four of seven residents (Resident R22, R4, R7, and R41). Findings include: Review of the facility policy Psychotropic Medication Use dated 1/8/26, with a previous review date of 1/14/25, indicated that residents will not receive medications that are not clinically indicated to treat a specific condition. A psychotropic drug is any medication that affects the brain activity associated with mental processes and behavior. PRN orders for psychotropic medications are limited to 14 days unless the physician believes it is appropriate to extend the use with documenting the rationale and evaluated the resident for appropriateness of the medication and includes the duration in the clinical record. Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. Review of the clinical record indicated Resident R22 was admitted on [DATE]. Review of Resident R22's MDS (Minimum Data Set- a periodic review of resident care needs) dated 2/15/26, indicated diagnoses which included head injury from a fall, parkinsonism, lung disease, depression and anxiety. Review of Resident R22's physician order dated 10/23/25, indicated to administer lorazepam (a medication used for short term management of anxiety disorders. It works by enhancing a neurotransmitter to sedate the central nervous system), 1mg tablet every six hours PRN (as necessary) for anxiety. Review of Resident R22's clinical record failed to reveal that the attending physician or prescribing practitioner evaluated the resident for the appropriateness of that medication. Review of the clinical record indicated Resident R4 was admitted on [DATE]. Review of Resident R4's MDS dated [DATE], indicated diagnoses of atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and osteomyelitis (inflammation of bone or bone marrow, usually due to infection). Further review of the MDS assessment failed to include a psychiatric or neurologic diagnosis. Review of the facility diagnosis list failed to include a psychiatric or neurologic diagnosis. Review of Resident R4's physician order dated 2/13/26, indicated to administer Abilify (Aripiprazole-an antipsychotic medication used to treat serious mental health conditions, including schizophrenia, bipolar I disorder), 5 mg daily. Review of the clinical record indicated Resident R7 was admitted on [DATE]. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R7's MDS dated [DATE], indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and muscle weakness. Review of Resident R7's physician order dated 8/12/25, indicated to administer haloperidol (antipsychotic medication used to treat schizophrenia, Tourette's disorder, and severe behavioral problems or acute agitation), 0.5mg every 24 hours PRN (as necessary) for agitation. Review of Resident R7's clinical record failed to reveal that the attending physician or prescribing practitioner evaluated the resident for the appropriateness of that medication. Review of the clinical record indicated Resident R41 was admitted on [DATE]. Review of Resident R41's MDS dated [DATE], indicated diagnoses of dementia and chronic pain. Review of Resident R41's physician order dated 11/25/25, indicated to administer haloperidol 0.5mg every twelve hours PRN for agitation. Review of Resident R41's clinical record failed to reveal that the attending physician or prescribing practitioner evaluated the resident for the appropriateness of that medication. During an interview on 3/6/26, at approximately 10:30 a.m. the Nursing Home Administrator confirmed that the facility failed to ensure that the residents medication regime was free from unnecessary psychotropic medication for four of seven residents. 28 Pa. Code 211.2(d)(3) Medical Director 28 Pa. Code 211.10(a) Resident care policies.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to conduct a thorough investigation of an injury obtained during care to eliminate possible neglect for one of two residents (Resident R8). Findings include: Review of facility policy Identifying Types of Abuse reviewed 1/8/26 with a previous review date of 14/25, Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Neglect as defined as, means 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 facility policy Accidents and Incidents- Investigating and Reporting dated 1/8/26, with a previous review date of 1/14/25, indicated that all accidents and incidents involving residents, employees, etc., occurring on the premises shall be investigated and reported to the Administrator. The Nurse Supervisor shall promptly initiate and document the investigation of the accident or incident. Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE]. Review Resident R8's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 2/14/26, indicated diagnoses of dementia, psychotic and mood disturbances, anxiety, obesity and dysphagia. Review of Resident R8's MDS dated [DATE], indicated substantial/maximal assistance for bed mobility. During a clinical record review, a progress note dated 1/7/26, indicated Resident R8 had a fall out of bed when being provided care which resulted in a laceration above her eyebrow which required treatment. Review of Resident R8's plan of care for Falls indicated resident is at risk for falls and to provide assistance as required. Bilateral fall mats to be in place. During an observation on 3/4/26, at 3:00 p.m., fall mat on right side of bed close to wall and leaning onto wall, no mat on left side of bed and Resident R8 had legs bent leaning towards left side of bed. During an observation on 3/5/26, at 9:00 a.m., fall mat on right side of bed unmoved from previous day and no mat on left side of bed. During an interview on 3/4/25, at 3:00 p.m., Registered Nurse Employee E6 and Nurse Aide (NA) Employee E7 stated that substantial/ maximal assistance requires two staff. During an interview on 3/5/26, at 9:00 a.m., NA Employee E8 stated that substantial/maximal assistance requires two staff. During an interview on 3/5/26, at 10:58 a.m., Therapy Manager Employee E9 stated that Resident R8 was not on caseload since 10/9/25, due to her inability to understand and follow commands and that care was identified to require two staff at all times due to her dementia progression. During an interview on 3/5/26, at 10:28 a.m., the Nursing Home Administrator confirmed that the facility failed to identify and conduct a thorough investigation of an injury obtained during care to eliminate possible neglect for one of five residents (Resident R8). 28 Pa Code: 201.18 (e)(1)(2) Management.28 Pa Code: 201.29 (a)(c) Resident Rights.28 Pa Code: 211.12 (a)(c)(d)(1)(3)(5) Nursing services.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on review of the Resident Assessment Instrument User's Manual and clinical records, and staff interview, it was determined that the facility failed to make certain that comprehensive Minimum Data Set assessments were accurate and fully completed for six of nine residents (Resident R7, R8, R16, R17, R41 and R8). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set Assessments (MDS - periodic assessment of care needs) dated October 2025, indicated that Section C: Cognitive Patterns, Question C0100 Should Brief Interview for Mental Status Be Conducted? (BIMS) should be coded as 0 if the resident is rarely/never understood, or it should be coded 1, and the BIMS assessment should be completed if the resident is at least sometimes understood. Section D: Mood, Question D0100 Should Resident Mood Interview Be Conducted? should be coded as 0 if the resident is rarely/never understood, and or it should be coded 1, and the assessment should be completed if the resident is at least sometimes understood. Section GG Mobility, indicated for how much assistance a resident requires for all mobility, eating and transfers. -Resident R7 had an MDS completed on 12/16/25. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R8 is understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R7 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question D0100 indicated that Resident R7 is rarely understood, and the Resident Mood Interview assessment was not completed. -Resident R8 had an MDS completed on 2/14/26. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R8 is sometimes understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R8 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question D0100 indicated that Resident R8 is rarely understood, and the Resident Mood Interview assessment was not completed. -Resident R16 had an MDS completed on 1/29/26. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R13 is sometimes understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R16 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question D0100 indicated that Resident R16 is rarely understood, and the Resident Mood Interview assessment was not completed. -Resident R17 had an MDS completed on 2/11/26. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R29 is sometimes understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R29 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question D0100 indicated that Resident R29 is rarely understood, and the Resident Mood Interview assessment was not completed. -Resident R41 had an MDS completed on 2/13/26. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R40 is understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R41 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question D0100 indicated that Resident R41 is rarely understood, and the Resident Mood Interview assessment was not completed. - Resident R8 had an MDS completed on 12/21/25. Review of Section GG Functional Abilities Section (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	0130 Question Self Care indicated that Resident R8 is 05 set up or clean up assistance. Section 0170 question Mobility rolling left to right indicated that Resident R8 is 02 substantial/maximal assistance for rolling left to right in bed for care. - Review of Resident R8's Documentation Survey Report V2(report that is produced from the Nurse Aide documented actual care provided and used when completing Section GG on the MDS) identified Resident R8 as 01 Dependent (the helper does all the effort). -Review of Resident R8's Documentation Survey Report VS identified Resident R8 as 01 Dependent for bed mobility rolling left to right for care. During an interview on 3/6/26, at approximately 11:30 a.m. the Resident Nurse Assessment Coordinator confirmed that the above Minimum Data Set assessments were inaccurate. During an interview on 3/6/26, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to make certain that comprehensive Minimum Data Set assessments were accurate and fully completed for five of nine residents. 28 Pa. Code: 211.5(f) Clinical records.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, observations, clinical record review, and staff interviews, it was determined that the facility failed to provide care and services needed for residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of two residents (Resident R26). Findings include: During an interview on 3/4/26, at 8:54 a.m., Resident R26 stated that she has itchiness around the abdomen due to the facility not providing latex free: incontinence pads prior to the night nurse finding her a latex free brief which does not fit properly and that she has not gotten her eye drops that the doctor ordered a couple days ago. Resident R26's daughter was on the phone with her and stated that she has a latex allergy, and the doctor told her the eye drops would help her because the resident has dry eyes. During an observation there was a tan colored brief laying on the windowsill, and a package of size large briefs had been opened and Resident R26 showed that it was too small for her. Resident R26's left eye appeared reddened. During an observation of the [NAME] nursing unit medication cart, Resident R26 did not have eye drops identified in the cart. During a review a latex allergy was indicated on Resident R26's clinical record and an order for Artificial Tears 2 drops both eyes twice per day and 1 drop both eyes every 6 hours as needed. During an interview on 3/4/26, at 11:08a.m., Registered Nurse Employee E5 stated she did not know why the eye drops had been documented as given and were not available. During an interview on 3/4/26, at 11:48 a.m., the Nursing Home Administrator confirmed that the facility failed to provide care and services needed for residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of two residents (Resident R26). 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of facility policy, observations, clinical records, and staff interviews, it was determined that the facility failed to make certain residents were provided necessary treatments and services, consistent with professional standards of practice, for a pressure ulcer (PU/PI - injuries to the skin and underlying tissues resulting from prolonged pressure on the skin) for one of three residents (Resident R1). Findings include: Review of the facility policy, Prevention of Pressure Ulcers/Injuries dated 1/8/26, previously dated 1/14/25, indicated the facility will identify pressure ulcer risk factors and interventions for specific risk factors. Review of the facility policy, Dressings, Dry/Clean dated 1/8/26, previously dated 1/14/25, indicated for staff to document that date and time the dressing was changed. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 12/9/25, included diagnoses of paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease) and neurogenic bladder (bladder problems due to disease or injury of the nervous system involved in the control of urination). Review of Section C: Cognitive Patterns indicated that Resident R1 was cognitively intact. Review of Section M: Skin Conditions indicated the presence of a Stage Four pressure ulcer (Full-thickness skin and tissue loss). Review of the plan of care dated 3/3/26, indicated that Resident R1 had actual skin impairment related to impaired mobility. Included in the interventions was, Administer treatment per physician order. Review of a physician's order dated 3/3/26, indicated that Resident R1 was to have dressing changes to sacral wound: Clean with acetic acid 1%, apply zinc oxide to peri wound, apply collagen, calcium alginate and apply abd (medical dressing) bid (twice daily) and prn (as needed). During a dressing change observation completed on 3/5/26, at 2:00 p.m. the following was observed: The soiled dressing removed was noted to be dated 3/3/26, without a documented time or staff member who performed the dressing change. LPN Employee E4 used normal saline solution to clean Resident R4's wound. LPN Employee E3 suggested the use of soap and water to clean Resident R4's wound. LPN Employee E4 stated that Resident R4's dressing change was to be completed once daily. Resident R4 responded to LPN Employee E4's comment and stated that he had not had twice daily dressing changes, in a very long time. Review of Resident R4's Treatment Administration Record (TAR) for March 2026, on 3/5/26, at 2:25 p.m. confirmed that Resident R4 was to receive twice daily dressing changes and confirmed that LPN Employee E2 had documented that she completed both the morning and evening dressing changes on 3/4/26. During an interview on 3/5/26, at 2:30 p.m. the Nursing Home Administrator and the Director of Nursing were informed that the dressing removed from Resident R4 during the dressing change observation on 3/5/26, was dated 3/3/26, and that incorrect information was entered on the TAR documenting that dressing changes were completed by LPN Employee E2 on 3/4/26, for both day and evening dressing change. During an interview on 3/6/26, at approximately 12:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to make certain residents were provided necessary treatments and services, consistent with professional standards of practice, for a pressure ulcer for one of three residents. 28 Pa. Code: 211.12(d)(5) Nursing Services.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 policy, clinical record and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision and assistance to prevent accidents for one of two residents (Resident R8). Findings include: Review of the facility policy Accidents and Incidents- Investigating and Reporting dated 1/8/26, with a previous review date of 1/14/25, indicated that all accidents and incidents involving residents, employees, etc., occurring on the premises shall be investigated and reported to the Administrator. The Nurse Supervisor shall promptly initiate and document the investigation of the accident or incident. Incident/Accident reports will be reviewed by the Safety Committee for trends related to the accident and analyze any individual resident vulnerabilities. Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE]. Review Resident R8's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 2/14/26, indicated diagnoses of dementia, psychotic and mood disturbances, anxiety, obesity and dysphagia. Review of Resident R8's MDS completed on 12/21/25. Review of Section GG Functional Abilities Section 0170 question Mobility rolling left to right indicated that Resident R8 is 02 substantial/maximal assistance for rolling left to right in bed for care. Review of Resident R8's Documentation Survey Report V2 (report that is produced from the Nurse Aide documented actual care provided and used when completing Section GG on the MDS) dated [DATE], identified Resident R8 as 01 Dependent for bed mobility rolling left to right for care. During a clinical record review, a progress note dated 1/7/26, indicated Resident R8 had a fall out of bed when being provided care which resulted in a laceration above her eyebrow which required treatment. Review of Resident R8's plan of care for Falls indicated resident is at risk for falls and to provide assistance as required. Bilateral fall mats to be in place. During an observation on 3/4/26, at 3:00 p.m., fall mat on right side of bed close to wall and leaning onto wall, no mat on left side of bed and Resident R8 had legs bent leaning towards left side of bed. During an observation on 3/5/26, at 9:00 a.m., fall mat on right side of bed unmoved from previous day and no mat on left side of bed. During an interview on 3/4/25, at 3:00 p.m., Registered Nurse Employee E6 and Nurse Aide (NA) Employee E7 stated that substantial/ maximal assistance requires two staff. During an interview on 3/5/26, at 9:00 a.m., NA Employee E8 stated that substantial/maximal assistance requires two staff. During an interview on 3/5/26, at 10:58 a.m., Therapy Manager Employee E9 stated that Resident R8 was not on caseload since 10/9/25, due to her inability to understand and follow commands and that care was identified to require two staff at all times due to her dementia progression. During an interview on 3/5/26, at 10:28 a.m., the Nursing Home Administrator confirmed that the facility failed to make certain each resident received adequate supervision and assistance to prevent accidents for one of two residents (Resident R8). 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.29(a)(c)(d) Resident rights.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on review of clinical records and staff interview, it was determined that the facility failed to provide documentation of medication regimen reviews (MRR) completed at least monthly for three of seven residents (Resident R7, R41 and R22). Findings include: On 3/5/26, the MRRs for Residents R7, R41 and R22 were requested, for the months of September 2025, through February 2026. During an interview on 3/6/26, at approximately 10:30 a.m. the Nursing Home Administrator confirmed that the facility was unable to locate the MRRs for Residents R7, R41 and R22. During an interview on 3/6/26, at approximately 12:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide documentation of medication regimen reviews completed at least monthly for three of seven residents. 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.5(f) Medical records. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of facility policy, observations, clinical records, and staff interviews, it was determined that the facility failed to appropriately document treatments for two of four residents (Residents R4 and R1). Findings include: Review of the facility policy, Charting and Documentation dated 1/8/26, previously dated 1/14/25, indicated All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Review of the facility policy, Dressings, Dry/Clean dated 1/8/26, previously dated 1/14/25, indicated for staff to document that date and time the dressing was changed. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs dated 2/19/26, included diagnoses of atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and osteomyelitis (inflammation of bone or bone marrow, usually due to infection). Review of the plan of care dated 2/13/26, indicated that Resident R4 had actual skin impairment related to an incision and drainage/osteomyelitis. Included in the interventions was, Wound vac dressing changes three times per week on M-W-F (Monday, Wednesday, Friday). Review of a physician's order dated 2/13/26, indicated that Resident R4's wound vac dressing to be changed three times per week on Monday, Wednesday, and Friday on day shift. During an interview on 3/4/26, at 2:45 p.m. Licensed Practical Nurse (LPN) Employee E2 stated Resident R4 had not had his wound vac dressing change completed yet that day. Review of Resident R4's Treatment Administration Record (TAR) for March 2026, on 3/4/26, at 2:50 p.m. revealed that LPN Employee E2 had documented that she had completed the wound vac dressing change. During an interview on 3/4/26, at 2:55 p.m. when asked to confirm if Resident R4's wound vac dressing change had been completed as she had stated it was not done, but had documented that it was done, LPN Employee E2 stated that LPN Employee E3 had completed the dressing change. During an interview on 3/4/26, at 3:02 p.m. LPN Employee E3 stated she had not completed Resident R4's dressing change. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of paraplegia and neurogenic bladder. Review of Section C: Cognitive Patterns indicated that Resident R1 was cognitively intact. Review of the plan of care dated 3/3/26, indicated that Resident R1 had actual skin impairment related to impaired mobility. Included in the interventions was, Administer treatment per physician order. Review of a physician's order dated 3/3/26, indicated that Resident R1 was to have dressing changes to sacral wound: Clean with acetic acid 1%, apply zinc oxide to peri wound, apply collagen, calcium alginate and apply abd (medical dressing) bid (twice daily) and prn (as needed). During a dressing change observation completed on 3/5/26, at 2:00 p.m. the soiled dressing removed was noted to be dated 3/3/26, without a documented time or staff member who performed the dressing change. During an interview, completed during the observed dressing change, on 3/5/26, at approximately 2:10 LPN Employee E4 stated that Resident R4's dressing change was to be completed once daily. At this time, Resident R4 responded to LPN Employee E4's comment and stated that he had not had twice daily dressing changes, in a very long time. Review of Resident R4's Treatment Administration Record (TAR) for March 2026, on 3/5/26, at 2:25 p.m. confirmed that Resident R4 was to receive twice daily dressing changes and confirmed that LPN Employee E2 had documented that she completed both the morning and evening dressing changes on 3/4/26. During an interview on 3/5/26, at 2:30 p.m. the Nursing Home Administrator and the Director of Nursing were informed that the dressing removed from Resident R4 during the dressing change observation on (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/5/26, was dated 3/3/26, and that incorrect information was entered on the TAR documenting that dressing changes were completed by LPN Employee E2 on 3/4/26, for both the day and evening dressing change. During an interview on 3/6/26, at approximately 12:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to appropriately document treatments for two of four residents. 28 Pa. Code: 211.5(f)(g)(h) Clinical records.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to offer pneumococcal disease vaccines in accordance with facility policy to seven of nine residents whose vaccines were reviewed. (Residents R5, R8, R14, R16, R12, R7 and R31). Findings include: Review of the facility policy Pneumococcal Vaccine dated 1/8/26 with a previous review date of 1/14/25, indicated that all residents are offered the pneumonia vaccine to aid in the prevention of pneumococcal pneumonia upon admission resident are assess for eligibility and when indicated will be offered the vaccine within 30 days of admission. Review of the clinical record indicated that Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's immunization documentation record did not include that the Pneumococcal vaccine was offered since admission. Review of the clinical record indicated that Resident R8 was admitted to the facility on [DATE]. Review of Resident R8's immunization documentation record did not include that the Pneumococcal vaccine was offered since admission. Review of the clinical record indicated that Resident R14 was admitted to the facility on [DATE]. Review of Resident R14's immunization documentation record did not include that the Pneumococcal vaccine was offered since admission. Review of the clinical record indicated that Resident R16 was admitted to the facility on [DATE]. Review of Resident R16's immunization documentation record did not include that the Pneumococcal vaccine was offered since admission. Review of the clinical record indicated that Resident R12 was admitted to the facility on [DATE]. Review of Resident R12's immunization documentation record did not include that the Pneumococcal vaccine was offered since admission. Review of the clinical record indicated that Resident R7 was admitted to the facility on [DATE]. Review of Resident R7's immunization documentation record did not include that the Pneumococcal vaccine was offered since admission. Review of the clinical record indicated that Resident R31 was admitted to the facility on [DATE]. Review of Resident R31's immunization documentation record did not include that the Pneumococcal vaccine was offered since admission. The last Pneumococcal vaccine had been given in 2013, according to the medical record. During an interview on 3/6/26, at 2:10 p.m., the Nursing Home Administrator confirmed that the facility failed to offer pneumococcal disease vaccines in accordance with facility policy to seven of nine residents whose vaccines were reviewed. (Residents R5, R8, R14, R16, R12, R7 and R31).		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility observations and staff interview, it was determined that the facility failed to maintain an effective call system for two of five restrooms accessible to residents. Findings include: During an observation on 3/4/26, at approximately 9:38 a.m. the staff restroom on the Garden nursing unit was unlocked. Observation of the restroom revealed no emergency call light or call cord attached for emergency use. During an observation on 3/4/26, at approximately 10:30 a.m. the staff restroom on the Garden nursing unit was unlocked, with the key hanging off the door knob, accessible to residents. Observation of the restroom revealed no emergency call light or call cord attached for emergency use. During an observation on 3/5/26, at approximately 9:45 a.m. the staff restroom on the [NAME] nursing unit was unlocked, with the key hanging on a magnetic hook approximately waist height, inside the restroom. Observation of the restroom revealed no emergency call light or call cord attached for emergency use. During an observation on 3/6/26, at approximately 9:30 a.m. the staff restroom on the [NAME] nursing unit was unlocked, with the key hanging on a magnetic hook approximately waist height, inside the restroom. Observation of the restroom revealed no emergency call light or call cord attached for emergency use. During an observation on 3/6/26, at approximately 11:30 a.m. the staff restroom on the Garden nursing unit was unlocked, with the key hanging off the door knob, accessible to residents. Observation of the restroom revealed no emergency call light or call cord attached for emergency use. During an interview on 3/6/26, at approximately 10:28 a.m. the Nursing Home Administrator confirmed the facility failed to maintain an effective call system for two of five restrooms accessible to residents. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (b) (1) Management		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident records, and resident and staff interview it was determined that the facility failed to maintain the privacy and dignity of one of six residents (Residents R3). Findings include: The facility policy Resident Rights dated 1/8/26, previously dated 1/14/25, indicated that facility residents have the right to a dignified existence. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 1/25/26, included Crohn's disease (chronic inflammatory bowel disease (IBD) causing severe, long-term inflammation) and history of a stroke. Review of Section C: Cognitive Patterns indicated Resident R3 was cognitively intact. During an interview completed on 3/5/26, at 9:08 a.m. Resident R3 stated that she was uncomfortable using the shower room on her nursing unit because a male resident's room opens directly into the shower room through an unlocked door. Observation of the Garden unit shower room revealed that it was directly accessed from Resident R20 through an internal door in the shower room. Review of Resident R20's clinical record revealed that he was mobile in his wheelchair. During an interview on 3/5/26, at approximately 10:30 a.m. the Nursing Home Administrator confirmed that the facility failed to uphold the privacy and dignity of one of six residents. 28 Pa Code: 201.29 (i) Resident rights.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review facility policy, clinical records, and staff interviews, it was determined that the facility failed to develop person-centered care plans for one of six residents (Resident R41). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set Assessments (MDS - periodic assessment of care needs) dated October 2025, indicated that Section V: Care Area Assessment (CAA) Summary instructions stated, For each triggered care area, Column B Care Planning Decision is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. Review of the facility policy Care Plans, Comprehensive Person-Centered dated 1/8/26, previously dated 1/14/25, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Review of the clinical record indicated Resident R41 was admitted on [DATE]. Review of Resident R41's MDS dated [DATE], indicated diagnoses of dementia, depression, and chronic pain. Review of Resident R41's comprehensive MDS dated [DATE], indicated psychotropic drug use was triggered in Section V: Care Area Assessment Summary. Review of the CAA Worksheet included the question, Will Psychotropic Drug Use be addressed in the care plan? This question was documented as Yes. Review of Resident R41's physician order dated 5/16/24, indicated to administer venlafaxine (an anti-depressant medication) 37.5 mg and 75 mg daily for depression. Review of Resident R41's physician order dated 11/25/25, indicated to administer haloperidol 0.5mg every twelve hours PRN for agitation. Review of Residents R41 care plan initiated 11/11/22, most recently revised 2/23/26, failed to include a plan of care developed for psychotropic drug use. During an interview on 3/6/26, at approximately 12:00 p.m. the Nursing Home Administrator confirmed the facility failed to develop person-centered care plans for one of six residents. 28 Pa. Code: 211.12 (d) (1) (2) (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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, facility policy review, and staff interviews, it was determined that the facility failed to ensure opened vials were labeled in accordance with currently accepted professional principles for one of one medication rooms([NAME] Medication Room) and medications obtained from the emergency machine for a resident were labeled in accordance with currently accepted professional standards for one of two medication carts ([NAME] Medication Cart). Findings include:Review of facility policy Medication Labeling and Storage, dated 1/8/26, with a previous review date of 1/14/25, indicated multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. Labeling of medications dispensed by the pharmacy is consistent with applicable federal and state requirements.During observation of the [NAME] medication storage room on 3/4/26, at 11:08 a.m., revealed one vial of tuberculosis purified protein derivative solution (PPD - used to determine resident or staff exposure or infection with tuberculosis) opened with no opened date written on the vial or the box that contained the vial.During an interview on 3/4/26, at 11:08 a.m., Registered Nurse Employee E5 confirmed that the one vial appeared accessed and that there was not an open date on the vial or box of the PPD solution.During an observation on 3/5/26, at 7:40 a.m., Registered Nurse Employee E4 removed a Nicotine Patch box containing an opened undated patch and stated that was the patch used for Resident R49. RN Employee E4 confirmed the box and parch were unlabeled and undated.29 Pa code 211.12(d)(1)(5) Nursing services		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395698	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2026
NAME OF PROVIDER OR SUPPLIER Meadowcrest Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 Braun Road Bethel Park, PA 15102	
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 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interview, it was determined the facility failed to post contact information for the Medicaid Fraud Unit on two of two nursing units ([NAME] and Garden nursing units). Findings include: During observations conducted on 3/4/25, at approximately 1:30 p.m. of the [NAME] and Garden nursing units revealed the facility revealed the facility did not have the Medicaid Fraud Unit contact information posted or accessible to residents. During an interview on 3/6/26, at approximately 12:00 p.m., the Nursing Home Administrator confirmed the facility failed to post contact information for the Medicaid Fraud on two of two nursing units. 28 Pa. Code: S201.29(i) Resident rights.		

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NAME OF PROVIDER OR SUPPLIER Meadowcrest Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 Braun Road Bethel Park, PA 15102	
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 0579 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide information about how to apply for and use Medicare and Medicaid benefits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interview, it was determined the facility failed to display written information on applying for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid on two of two nursing units ([NAME] and Garden nursing units). Findings include: Observations conducted on 3/4/25, at approximately 1:30 p.m. of the [NAME] and Garden nursing units, revealed the facility failed to include information on how to apply for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid . During an interview on 3/6/26, at approximately 12:00 p.m., the Nursing Home Administrator confirmed the facility failed to display written information on applying for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid on two of two nursing units. 28 Pa. Code: S201.29(i) Resident rights.		

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NAME OF PROVIDER OR SUPPLIER Meadowcrest Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 Braun Road Bethel Park, PA 15102	
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 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and staff interview, it was determined that the facility failed to post the most recent Federal or State survey results for one of one survey books observed (located in main entrance lobby). Findings Include: Observation of the survey binder located in the main entrance lobby on 3/4/26, at 1:30 p.m., revealed the most recent survey results present were dated 9/11/24. Review of the facility's survey history revealed surveys dated: 1/8/25, 4/30/25, 6/11/25, 7/28/25, 9/3/25, 11/4/25, 12/2/25, 1/14/26, and 2/12/26. During an interview on 3/6/26, at approximately 12:00 p.m. the Nursing Home Administrator confirmed the facility failed to post the most recent Federal or State survey results for one of one survey books. 28 Pa. Code 201.14 Responsibility of licensee		