

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  396003	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/13/2025
NAME OF PROVIDER OR SUPPLIER  Monroeville Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  885 MacBeth Drive 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 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.  (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

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of clinical record was determined that the facility failed to develop a person-centered care plan related to falls for one of five residents (Residents R15). This was identified as past non-compliance. Findings include: Review of the facility policy, Fall Risk Assessment dated 6/20/25, indicated, The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. Review of the facility policy, Care Plans, Comprehensive Person-Centered dated 6/20/25, 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 R15 was admitted to the facility on [DATE]. Review of the minimum data set (MDS, periodic assessment of resident care needs) dated 6/24/25, included diagnoses of anemia (too little iron in the body causing fatigue), cancer, and multiple fractures. Review of Section V: Care Area Assessment revealed that Falls was triggered to review for care plan development. Review of a nurse practitioner's note created 6/18/25, at 9:27 a.m. indicated Resident R15 was admitted to the facility after hospitalization due to falls. Assessing this patient today due to risks of falls possibly leading to fracture or other significant injury, decreased participation in therapy with longer length of stay, aspiration and/or anorexia due to weakness and fatigue. All potentially leading to rehospitalization and/or death. Review of a Fall Risk Observation Assessment dated 6/18/25, indicated that Resident R15 was at high risk for falls. Review of a progress note dated 7/9/25, at 7:00 a.m. indicated, Called to assess resident post fall. Resident observed on floor next to bed. Resident has terminal restlessness and agitation. Call light was in reach, not activated. Resident was not incontinent. Resident has small skin tear to right elbow, cleansed with NS and optifoam (silicone faced foam dressing) applied. Resident assisted into bed per facility protocol. Fall mats applied. Hospice and family notified. Review of a change in condition note dated 7/10/25, at 10:32 a.m. indicated Resident R15 was experiencing Falls Pain (uncontrolled) Urinary incontinence (new or worsening) New or Worsening Pain. Review of Resident R15's care plan initiated on 6/18/25, and active on 7/9/25, indicated, Resident is at risk for falls with or without injury related to unsteady gait, history of falls with the intervention of Keep call light within reach. No other interventions to prevent falls were documented. Review of facility submitted information dated 7/17/25, indicated Family member called APS (Adult Protective Services) alleging neglect after her fall on 7.9.2025 for a lack of fall interventions. APS alerted facility on 7.17.2025 of this accusation. Review of fall care plan shows it was initiated on 6.18.2025. Fall mats added as an intervention post fall. No injuries noted and no further falls. Terminal agitation a factor. Multiple hospice and CRNP (certified nurse practitioner) visits and medication adjustments have been made. This incident will be taken to QA (Quality Assurance) for tracking and trending. <b>**the original fall did not meet criteria as a reportable event. A more robust fall care plan for new admissions to be discussed.**</b> *Resident rolled out of bed. Bed was in low position and call bell in reach but not activated. Fall mats put in place post fall. <b>**</b> On 7/17/25, the facility initiated a plan of correction that included:-QAPI (Quality Assurance and Performance Improvement) performance improvement plan initiated on 7/17/25.-Education to nursing leadership regarding rounding related to fall care plans.-Audits of new admissions for fall care plan completion.-Staff meetings completed 8/7/25 on rounding and fall care plans. -Current plans of care were updated as appropriate. During an electronic communication on 8/13/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed the facility failed to develop a person-centered care plan related to falls for one of five residents. This was identified as past non-compliance.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on review of resident and staff interviews, and grievance review, it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of 14 of 20 residents (Residents R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, and R14). Findings include: During an interview on 8/10/25, at 2:40 p.m. when asked if he felt the facility maintained enough staff to care for resident needs, Resident R1 stated, No. Resident R1 stated that call light response takes a long time. During an interview on 8/10/25, at 2:42 p.m. when asked if he felt the facility maintained enough staff to care for resident needs, Resident R2 stated, Could be better. During an interview on 8/10/25, at 2:43 p.m. when asked if he felt the facility maintained enough staff to care for resident needs, Resident R3 stated, Not at all. Resident R2 further stated that call light response times can be long and he waits a long time for assistance to get out of bed. During an interview on 8/10/25, at 2:47 p.m., Resident R4, when asked if she felt the facility maintained sufficient staff to care for resident needs, stated that sometimes she needs to wait a long time for call light response. During an interview on 8/10/25, at 2:50 p.m., Resident R5, when asked if she felt the facility maintained sufficient staff to care for resident needs, stated, No, I think they could use more help. Resident R5 further stated that call light response times can be long. During an interview on 8/10/25, at 2:56 p.m., Resident R6, when asked if she felt the facility maintained sufficient staff to care for resident needs, stated that call light response time was sometimes good, sometimes bad. During an interview on 8/10/25, at 2:58 p.m., Resident R7, when asked if she felt the facility maintained sufficient staff to care for resident needs, stated, No. Too long to answer the call lights. I've been hollering help. Nobody came. During an interview on 8/10/25, at 4 14p.m., Resident R8, when asked if she felt the facility maintained sufficient staff to care for resident needs, stated, No. Resident R8 further stated that sometimes it takes an hour or more for call light response. Sometimes I'm in excruciating pain, and it takes an hour to get my pain meds. It's horrible. During an interview on 8/10/25, at 4 18 p.m., Resident R9, when asked if she felt the facility maintained sufficient staff to care for resident needs, stated, Hell no. When asked about call light response time, Resident R9 stated, Well it all depends on if it's close to quitting time. Can be 45 minutes to an hour. You push the button, the don't even answer. Resident R9 stated she would like more showers, I don't like the smell of myself. Observation at this time confirmed that Resident R9 was malodorous. During an interview on 8/10/25, at 4 23 p.m., Resident R10, when asked if she felt the facility maintained sufficient staff to care for resident needs, stated, Not really and stated call light response time can be long. During a confidential staff interview, when asked if the staff member felt there was sufficient staff to care for resident needs, the staff member stated, Absolutely not. We are running our asses off. Friday night there was one nurse up (second floor) and one nurse down (first floor), and one supervisor. We've had an increase in fall, increase in wounds, increase in not getting shit done. Review of a grievance filed on behalf of Resident R11, dated 5/28/25, revealed concerns documented for incontinence care, grooming, availability of fresh water, protective booties not applied, and call light availability. Review of a grievance generated from a resident council meeting dated 7/15/25, indicated Multiple residents reported wait time of 30 minutes for call lights to be answered. Review of a grievance filed on behalf of Resident R12, dated 7/25/25, indicated Resident R12 reported to a staff member, [Resident R12 has filed 3 grievances and no one has gotten back to her. Her roommate/husband [Resident R13] was tangled up in a phone cord, his urine bottle spilled and was all over the floor, and she and her husband both needed to be changed but the aide never came in to help them. The nurse told her to turn the aide in for not showing up. [Resident R12] tried calling the supervisor but only got a dial tone, so she called me instead. This all happened at 4:00 p.m. When I went up to the second floor to ask for help I saw [two staff members] were helping them. Review of a grievance filed on behalf of Resident R14, dated 7/30/25, revealed concerns documented for incontinence care and call light response times. During an electronic communication on 8/13/25, at approximately 1:00 p.m. the Nursing Home Administrator and confirmed that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of 14 of 20 residents. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(6) Management. 28 Pa. Code: 201.20(a) Staff development. 28 Pa. Code: 211.12(a)(c)(d)(1)(2)(3)(4) Nursing services.</p>		