STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396003	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroeville Post Acute	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 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 review of facility policy, observations, and staff interview, it was determined that the facility failed to make certain that medications were properly stored and/or disposed of in two of four medication carts (First Floor-South/East Hall, Second Floor-South/East Hall).Finding include:Review of facility policy Medication Storage in the Facility: Storage of Medications dated [DATE], [DATE], and [DATE], stated that medications and biologicals that have an expired date on the label, have been retained longer than recommended by manufacturer or supplier guidelines are stored separate from other medications until destroyed or returned to the pharmacy or supplier. The policy further stated that multiple dose injectable vials and ophthalmics, once opened, require an expiration date shorter than the manufacturer ' s expiration date to insure medication purity and potency.During an observation of the first-floor medication cart on [DATE], at approximately 8:55 a.m. the following was observed:-(1) bottle of Pat-a-day eye drops, open and undated.-(1) bottle of Pat-a-day, dated as opened on [DATE] on the box with no date written on the bottle.-(1) bottle of Visine, dated as opened on box 11/25, no date written on bottle.-(1) bottle of Timoptic Opth. Solution, dated as opened on box 11/25, no date written on bottle.-(1) bottle of Brimonidine Tartrate Opth. Solution, dated on box as 11/25, no date written on bottle. -(1) bottle of Pepto-Bismol, opened and undated.-(2) bottles of Lactulose, opened and undated. During an observation of the second-floor medication cart on [DATE], at approximately 9:08 a.m. the following was observed:-(2) bottles of Pat-a-day eye drops were dated on box 11/25, with no date documented on bottle.-(1) bottle Timoptic Opth. Solution was dated [DATE], with no date documented on bottle.-(1) bottle Visine was dated [DATE], with no date documented on bottle.-(1) bottle Systane was dated 11/25, with no date documented on bottle.-(1) bottle Pepto-Bismol, opened and undated.-(2) bottles of Robitussin, opened and undated.Employee E1 confirmed that the above observation of medications being labeled with dates on boxes or no dates at all were noted on the multi-dose bottles that were in her cart when she started medication administration.During an interview on [DATE], at approximately 9:20 a.m. the Director of Nursing confirmed that the facility failed to make certain that our of date medications were properly stored and/or disposed of in two of four medication carts. 28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.18 (b)(1)(e)(1) Management.28 Pa Code: 211.9 (a)(1) Pharmacy services.28 Pa Code: 211.12 (d)(1)(3)(5) Nursing services.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **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 ensure that the resident and/or their representative received written notice of the facility bed-hold policy at the time of transfer for three of six residents reviewed for hospitalization (Resident R6, R27, and R116).Findings include: Review of federal regulation S483.15(d) Notice of Bed-Hold Policy, indicated, facilities must provide written information about these policies to residents prior to and upon transfer for such absences. This information must be provided to all facility residents, regardless of their payment source. These provisions require facilities to issue two notices related to bed-hold policies. The first notice could be given well in advance of any transfer, i.e., information provided in the admission packet. Reissuance of the first notice would be required if the bed-hold policy under the State plan or the facility's policy were to change. The second notice must be provided to the resident, and if applicable the resident's representative, at the time of transfer, or in cases of emergency transfer, within 24 hours. It is expected that facilities will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. The notice must provide information to the resident that explains the duration of bed-hold, if any, and the reserve bed payment policy. It should also address permitting the return of residents to the next available bed. Review of the clinical record indicated Resident R6 was initially admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 8/26/25, included diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels) and heart failure (a progressive heart disease that affects pumping action of the heart muscles). Review of a progress note dated 10/19/25, at 10:29 p.m. indicated that Resident R6 was transported to the hospital for altered mental status. Review of a progress note dated 10/20/25, at 12:48 a.m. indicated Resident R6 was admitted to the hospital for low potassium. Further review of Resident R6's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the resident or resident representative upon transfer. Review of the clinical record indicated Resident R27 was initially admitted to the facility on [DATE], and he was readmitted on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and high blood pressure. Review of a progress note dated 10/27/25, at 1:30 p.m. indicated that Resident R27 was transported to the hospital for altered mental status and facial swelling. Further review of Resident R27's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the resident or resident representative upon transfer. Review of the clinical record indicated Resident R116 was initially admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of heart failure and muscle wasting. Review of a progress note dated 11/8/25, at 1:44 a.m. indicated that Resident R116 was transported to the hospital for fever and abnormal vital signs. Further review of Resident R116's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the resident or resident representative upon transfer. During an interview on 11/20/25, at approximately 1:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to ensure that the resident and/or their representative received written notice of the facility bed-hold policy at the time of transfer for three of six residents reviewed for hospitalization. 28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	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 two of eight residents (Resident R11 and R27).Findings include: Review of the facility policy Care Plans, Comprehensive Person-Centered dated 6/20/25, indicated, The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan foreach resident. Review of facility census information revealed that Resident R11 and Resident R27 share a room. Review of the clinical record indicated Resident R11 was initially admitted to the facility on [DATE], and she was readmitted on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 8/26/25, included diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels) and end stage renal disease (ESRD, an inability of the kidneys to filter the blood). Review of the plan of care last reviewed 9/8/25, indicated in the Activities care plan, Resident has a significant other at facility. Further review of Resident R11's plan of care failed to reveal a plan of care developed for a personal relationship with a peer resident. Review of the clinical record indicated Resident R27 was initially admitted to the facility on [DATE], and he was readmitted on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and high blood pressure. Review of the plan of care last reviewed 11/11/25, indicated in the Activities care plan, Resident does have a significant other here at facility. Further review of Resident R11's plan of care failed to reveal a plan of care developed for a personal relationship with a peer resident. During an interview on 11/20/25, at approximately 1:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to develop person-centered care plans for two of eight residents. 28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.