

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395295	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/10/2024
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NAME OF PROVIDER OR SUPPLIER: WECARE AT MURRYSVILLE REHABILITATION AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 3300 LOGANS FERRY ROAD MURRYSVILLE, PA 15668
STATE LICENSE NUMBER: 134702	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0625 SS=D	Based on an Abbreviated Survey in response to two complaints, completed on December 10, 2024, it was determined that Wecare at Murrysville Rehab and Nursing was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0625		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0625 SS=D	Continued from page 1 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 0625	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. The facility cannot correct that Resident R1 or resident's representative was not notified of the bed hold policy at the time of transfer to the hospital on 11/22/24. 2. The facility will ensure when residents are transferred to the hospital, the resident/representative will be provided written information about the facility bed hold policy.	Completion Date: 01/07/2025 Status: APPROVED Date: 12/20/2024

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F 0625 SS=D	Continued from page 2	F 0625	<p>3. The Nursing Home Administrator/designee with re-educate the business office and social service staff on the facility bed hold policy. The Director of Nursing/designee will re-educate the licensed nursing staff on the facility bed hold policy.</p> <p>4. The Social Service/Designee will audit resident transfers to the hospital twice weekly for two weeks, weekly for two weeks and monthly for three months to ensure the bed hold policy is being followed. Results of the audits will be presented to the quality assurance performance improvement committee for review and further recommendations.</p>	

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F 0625 SS=D	Continued from page 3 Based on review of facility document, clinical records, and staff interviews, it was determined that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for one of two resident hospital transfers (Resident R1). Findings Include: Review of the facility document "Admission Agreement" indicated that before a resident may be transferred to a hospital or for therapeutic leave, the facility is required to provide the facility's Bed Hold Policy to the resident and a family member or Resident Representative. Review of the clinical record indicated Resident R1 was admitted to the facility on 6/16/22. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/1/24, indicated diagnoses of high blood pressure,	F 0625		

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F 0625 SS=D	Continued from page 4 diabetes (a disorder in which the body has high sugar levels for prolonged periods of time), and difficulty in walking. Review of Resident R1's clinical record revealed that the resident was transferred to the hospital on 11/22/24. Review of Resident R1's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 11/22/24. During an interview on 12/9/24, at 12:27 p.m. the Director of Nursing confirmed that the facility failed to notify the resident or resident's representative of the facility bed-hold policy for Resident R1. 28 Pa. Code: 201.29(b)(d)(j) Resident rights.	F 0625		

Pennsylvania Department of Health

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P 5520		P 5520		

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P 5520	Continued from page 1 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	1. The facility cannot correct that the nurse aide ratio staffing was not meet on 11/24/24, 11/28/24, 11/29/24, 11/30/24, 12/1/24, 12/2/24, 12/3/24, 12/4/24, 12/5/24, 12/6/24 and 12/7/24. There were no adverse effects to residents on the identified dates. 2. The facility will ensure that staffing ratios are met every shift. 3. Nursing administration and the scheduler will be re-educated by the Nursing Home Administrator/designee on ensuring staffing ratios are meet each shift. Daily shift staffing ratios will be reviewed at Standup and Stand down. The Nursing Supervisors will review shift staffing ratios on the weekends. If the facility projects not to meet staffing ratios on a shift, nursing administration/designee will be responsible to call off duty personnel or call extra support staff to assist. 4. The Nursing Home Administrator/designee will audit	Completion Date: 01/07/2025 Status: APPROVED Date: 12/20/2024

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P 5520	Continued from page 2	P 5520	staffing daily for four weeks and monthly for three months to ensure staffing ratios are being met. Outcomes will be reported to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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P 5520	Continued from page 3 Based on review of nursing time schedules and staff interviews it was determined that the facility administrative staff failed to provide a minimum of one nurse aide per ten residents during the day shift for six of 14 days (11/24/24, 11/28/24, 11/29/24, 12/1/24, 12/6/24, and 12/7/24), failed to provide a minimum of one nurse aide per 11 residents during the evening shift for four of 14 days (11/28/24, 11/29/24, 12/1/24, and 12/6/24), and failed to provide a minimum of one nurse aide per 15 residents on the night shift for ten of 14 days (11/24/24, 11/28/24, 11/29/24, 11/30/24, 12/2/24, 12/3/24, 12/4/24, 12/5/24, 12/6/24, and 12/7/24). Findings include: Review of facility census data, nursing time schedules from 11/24/24 through 12/7/24 revealed the following nurse aide staffing shortages. Day shift: Date Census Full time equivalents (FTE) required FTE present	P 5520		

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P 5520	Continued from page 4 11/24/24 82 8.2 5.7 11/28/24 81 8.1 7.9 11/29/24 81 8.1 4.59 12/1/24 81 8.1 7.0 12/6/24 83 8.3 8.03 12/7/24 85 8.5 4.97 Evening shift: Date Census FTE required FTE present 11/28/24 81 7.36 6.03 11/29/24 81 7.36 7.0	P 5520		

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P 5520	Continued from page 5 12/1/24 81 7.36 7.0 12/6/24 83 7.55 6.10 Night shift: Date Census FTE required FTE present 11/24/24 82 5.47 5.0 11/28/24 81 5.4 4.2 11/29/24 81 5.4 4.33 11/30/24 81 5.4 5.19 12/2/24 80 5.33 4.43 12/3/24 82 5.47 5.0 12/4/24 83 5.53 5.4	P 5520		

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P 5520	Continued from page 6 12/5/24 83 5.53 5.4 12/6/24 83 5.53 5.07 12/7/24 85 5.67 5.3 During an interview on 12/10/24, at 12:35 p.m. Director of Nursing confirmed that the facility failed to provide a minimum of one nurse aide per 10 residents during the day, and one nurse aide per 11 residents during the evening shift, and one nurse aide per 15 residents on the night shift, with no additional excess higher-level staff to compensate this deficiency.	P 5520		
P 5530		P 5530		

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P 5530	Continued from page 7 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	<p>1. The facility cannot correct that LPN staffing ratio was not meet on 11/25/24, 11/29/24 and 12/1/24. There were no adverse effects to residents on the identified dates.</p> <p>2. The facility will ensure that staffing ratios are met every shift.</p> <p>3. Nursing administration and the scheduler will be re-educated by the Nursing Home Administrator/designee on ensuring staffing ratios are meet each shift. Daily shift staffing ratios will be reviewed at Standup and Stand down. The Nursing Supervisors will review shift staffing ratios on the weekends. If the facility projects not to meet staffing ratios on a shift, nursing administration/designee will be responsible to call off duty personnel or call extra support staff to assist.</p> <p>4. The Nursing Home Administrator/designee will audit staffing daily for four weeks and monthly for three months to ensure</p>	Completion Date: 01/07/2025 Status: APPROVED Date: 12/20/2024

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P 5530	Continued from page 8	P 5530	staffing ratios are being met. Outcomes will be reported to the Quality Assurance Performance Improvement Committee for review and recommendations	

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P 5530	Continued from page 9 Based on review of nursing time schedules and staff interview it was determined that the facility administrative staff failed to provide a minimum of one licensed practical nurse (LPN) per 40 residents during the night shift on three of 14 days (11/25/24, 11/29/24, and 12/1/24). Findings include: Review of facility census data, nursing time schedules from 11/24/24 through 12/7/24 revealed the following LPN staffing shortages. Night shift: Date Census FTE required FTE present 11/25/24 81 2.03 1.97 11/29/24 81 2.03 1.94 12/1/24 81 2.03 1.99	P 5530		

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P 5530	Continued from page 10 During an interview on 12/10/24, at 12:35 p.m. the Director of Nursing confirmed the staffing shortages and that the facility failed to provide one LPN per 40 residents during the night shift as required with no additional excess higher-level staff to compensate this deficiency.	P 5530		
P 5640		P 5640		

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P 5640	Continued from page 11 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	<ol style="list-style-type: none"> 1. The facility cannot correct that the State required PPD (per patient daily) minimum hours of 3.20 was not meet on 11/24/24, 11/28/24, 11/29/24, 12/1/24, 12/2/24, 12/3/24, 12/5/24, 12/6/24, 12/7/24 2. The facility will provide a minimum of 3.20 hours of direct care for each resident. 3. Nursing Administration and the scheduler will be re-educated by the Nursing Home Administrator/designee on the required minimum PPD of 3.20. A staffing meeting will occur Monday through Friday to review daily PPD. Nursing supervisors will monitor on weekends. If the facility is projected to not meet staffing PPD the scheduler/or designee will call off duty facility staff, and will utilize external staffing support resources. 4. Nursing Home Administrator/designee will audit staffing daily for three weeks and monthly for three months to ensure 	Completion Date: 01/07/2025 Status: APPROVED Date: 12/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395295	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/10/2024
NAME OF PROVIDER OR SUPPLIER: WECARE AT MURRYSVILLE REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 3300 LOGANS FERRY ROAD MURRYSVILLE, PA 15668		
STATE LICENSE NUMBER: 134702				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5640	Continued from page 12	P 5640	staffing ratios and PPD are being met. Outcomes will be reported to the Quality Assurance Performance Improvement Committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395295	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/10/2024
NAME OF PROVIDER OR SUPPLIER: WECARE AT MURRYSVILLE REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 3300 LOGANS FERRY ROAD MURRYSVILLE, PA 15668		
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P 5640	Continued from page 13 Based on review of nursing time schedules and staff interviews it was determined that the facility administrative staff failed to provide the minimum number of general nursing hours to each resident in a 24-hour period on nine of 14 days (11/24/24, 11/28/24, 11/29/24, 12/1/24, 12/2/24, 12/3/24, 12/5/24, /12/6/24, and 12/7/24). Findings include: Nursing time schedules for the time frame of 11/24/24 through 12/7/244 revealed that the facility failed to maintain 3.2 hours of general nursing care to each resident in a 24-hour period on the following dates: 11/24/24 - 2.99 11/28/24 - 2.87 11/29/24 - 2.67 12/1/24 - 3.01 12/2/24 - 3.14 12/3/24 - 3.19 12/5/24 - 3.19	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395295	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 12/10/2024
NAME OF PROVIDER OR SUPPLIER: WECARE AT MURRYSVILLE REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE: 3300 LOGANS FERRY ROAD MURRYSVILLE, PA 15668		
STATE LICENSE NUMBER: 134702					
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P 5640	Continued from page 14 12/6/24 - 2.98 12/7/24 - 2.86 During an interview on 12/10/24, at 12:35 p.m. the Director of Nursing confirmed that the facility failed to provide the minimum number of general nursing hours to each resident in a 24-hour period on nine of 14 days.	P 5640			



Certified End Page

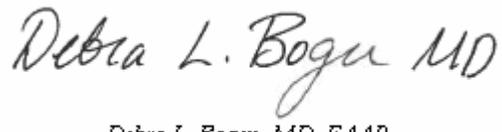
WECARE AT MURRYSVILLE REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 134702

SURVEY EXIT DATE: 12/10/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY