STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395670	A. BLDG: 00 B. WING:	03/31/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WECARE AT MONROEVILLE REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **026102**	**4142 MONROEVILLE BOULEVARD MONROEVILLE, PA 15146**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 Based on an Abbreviated survey in response to seven complaints completed on March 31, 2025, it was determined that WeCare Monroeville Rehabilitation and Nursing Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey.	F 0000		
F 0580 SS=E		F 0580		

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 0580 SS=E	Continued from page 1 483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this	F 0580	The responsible parties for Residents R10, R11, and R2 were contacted immediately upon identification of the deficiency to provide retrospective notification and updates on the resident's condition and treatment. The attending physicians and providers were also notified where clinical follow-up was necessary. Progress notes were updated to reflect the communications and any interventions completed post-notification. DON/designee conducted house audit for New medication orders, Changes in condition, for transfer to hospital, from 3/31-4/21, and validate Documentation of notification to the physician and resident representative. The DON/designee will provide education to licensed nurses to ensure, Notifications must occur for residents with change in condition, new treatment orders, and transfers out to hospital by 4/30/25.	Completion Date: **05/06/2025** Status: **APPROVED** Date: **04/25/2025**

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F 0580 SS=E	Continued from page 2 section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:	F 0580	The Director of Nursing (DON) or designee will perform audit on the following New medication orders, Changes in condition, transfer to hospital, and Documentation of notification to the physician and resident representative; 5 days per week for 4 weeks then 3 days per week for 2 weeks.	

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F 0580 SS=E	Continued from page 3 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to notify resident representative and/or medical providers of a newly ordered medication or a change in condition for three of seven residents (Resident R10, R11, and R2). Findings include: Review of the policy "Next of Kin Notification for Medication Changes", dated 1/22/25, indicated the interdisciplinary team shall notify the next of kin or designated responsible party/HCP (healthcare proxy)/POA (power of attorney) of medication changes for residents in a timely manner to promote informed decision-making and continuity of care. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2024, indicated that a Brief Interview for Mental Status ("BIMS"), is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:	F 0580		

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F 0580 SS=E	Continued from page 4 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of Resident R10's clinical admission record indicated that resident was initially admitted to the facility on 12/16/24, and readmitted on 3/6/25. Review of Resident R10's Minimum Data Set (MDS, periodic assessment of care needs) dated 3/3/25, included diagnoses of osteoporosis (condition when the bones become brittle and fragile), high blood pressure, and intellectual disabilities. Section C: Cognitive Patterns revealed a BIMS score of "03." Review of Resident R10's demographic information in her electronic medical record indicated that Resident R10 had a healthcare power of attorney. Review of physician orders revealed that Resident R10 had the following orders for Eliquis (an anticoagulant medication):	F 0580		

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F 0580 SS=E	Continued from page 5 1/6/25 - 1/9/25: 2.5 mg (milligrams) twice daily. 1/9/25 - 2/24/25: 5 mg twice daily. 2/25/25 - 3/3/25: 2.5 mg twice daily. Review of a nurse practitioner progress note dated 1/6/25, created at 9:41 p.m. indicated, "Begin Eliquis 5mg BID for 3 days then 2.5mg BID (twice daily)." Review of a physician progress note dated 1/8/25, created at 9:41 p.m. indicated, "Continue Eliquis 5mg BID." Further review of progress notes failed to reveal a communication to the resident representative of the newly ordered anticoagulant medication. Review of Resident R11's clinical admission record indicated that resident was admitted to the facility on 1/5/25. Review of Resident R11's MDS dated 1/9/25, included diagnoses of atrial fibrillation (disease of the	F 0580		

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F 0580 SS=E	Continued from page 6 heart characterized by irregular and often faster heartbeat), anemia (too little iron in the body causing fatigue), and cirrhosis (chronic damage leading to scarring and failure) of the liver. Section C: Cognitive Patterns revealed a BIMS score of "10." Review of Resident R11's demographic information in his electronic medical record indicated that Resident R11's spouse as his responsible party. Progress notes on 1/8/25, at 1:50 p.m. and 1/13/25, at 7:02 p.m. both documented Resident R11's spouse as his healthcare decision maker. Review of a progress note dated 1/5/25, at 9:21 p.m. revealed Resident R11 was on contact isolation for c-diff (Clostridium difficile, bacterium that causes diarrhea and inflammation of the colon). Review of a progress note dated 1/9/25, at 2:34 p.m. indicated that Resident R11 stated "he does not want to eat because he feels as though he will have an emesis."	F 0580		

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F 0580 SS=E	Continued from page 7 Review of a progress note dated 1/13/25, at 2:50 p.m. indicated Resident R11 complained of not feeling well. The note additionally stated that Resident R11 was to begin intravenous fluids for hydration." Review of a nurse practitioner progress note dated 1/13/25, created at 7:02 p.m. indicated, "Begin Eliquis 5mg BID for 3 days then 2.5mg BID (twice daily)." Review of a physician progress note dated 1/8/25, created at 9:41 p.m. indicated, " When seeing patient today he kept repeating he "didn't feel well." Unable to verbalize what was wrong." Review of a progress note dated 1/12/25, at 10:31 p.m. indicted Resident R11 ate less than 25% of his meal. Review of a therapy progress note dated 1/14/25, at 1:28 p.m. indicated that therapy staff attempted to complete occupational therapy, but that Resident	F 0580		

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F 0580 SS=E	Continued from page 8 R11 refused stating he has been throwing up all day. Review of a progress note dated 1/14/25, at 8:30 p.m. indicated Resident R11 experienced dark projectile vomiting. The note indicated the provided was notified at this time. Review of Resident R11's meal consumption record revealed the following: 1/6/25, Breakfast: No documentation of meal consumed 1/6/25, Lunch: No documentation of meal consumed 1/6/25, Dinner: 26-50% of meal consumed 1/7/25, Breakfast: No documentation of meal consumed 1/7/25, Lunch: No documentation of meal consumed 1/7/25, Dinner: 26-50% of meal consumed 1/8/25, Breakfast: No documentation of meal consumed 1/8/25, Lunch: No documentation of meal consumed	F 0580		

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F 0580 SS=E	Continued from page 9 1/8/25, Dinner: 76-100% of meal consumed 1/9/25, Breakfast: No documentation of meal consumed 1/9/25, Lunch: No documentation of meal consumed 1/9/25, Dinner: 26-50% of meal consumed 1/10/25, Breakfast: 76-100% of meal consumed 1/10/25, Lunch: 76-100% of meal consumed 1/10/25, Dinner: 0-25% of meal consumed 1/11/25, Breakfast: Resident refused 1/11/25, Lunch: Resident refused 1/11/25, Dinner: 51-75% of meal consumed 1/12/25, Breakfast: No documentation of meal consumed 1/12/25, Lunch: No documentation of meal consumed 1/12/25, Dinner: 51-75% of meal consumed 1/13/25, Breakfast: 76-100% of meal consumed 1/13/25, Lunch: 26-50% of meal consumed 1/13/25, Dinner: 76-100% of meal consumed Review of Resident R11's physician's orders failed to reveal any orders for medications to treat nausea	F 0580		

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F 0580 SS=E	Continued from page 10 and vomiting. Review of the Medication Administration record confirmed that Resident R11 did not receive any medicinal support to treat nausea and vomiting. Further review of progress notes failed to reveal a communication to the resident representative of the initiation of intravenous fluids, and failed to reveal a communication to the medical provider to notify them of Resident R11's low food consumption, refusal of meals, or to request treatment for Resident R11's nausea and vomiting. Review of Resident R2's clinical admission record indicated that resident was initially admitted to the facility on 1/10/25, and readmitted on 1/30/25. Review of Resident R2's MDS dated 1/14/25, included diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), high blood pressure, and a psychotic disorder. Section C: Cognitive Patterns revealed a BIMS score of "6."	F 0580		

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F 0580 SS=E	Continued from page 11 Review of Resident R2's demographic information in his electronic medical record indicated that Resident R2's daughter as her responsible party and power of attorney. Progress notes on 1/20/25, at 1:52 p.m., 1/27/25, at 1:35 p.m., and 2/17/25, at 5:27 p.m. all documented Resident R2's daughter as her healthcare decision maker. Review of a progress note dated 2/25/25, at 7:56 p.m. indicated, "Resident was found sitting on the toilet (at 7PM) and not responding to verbal stimuli; as a result, she fell onto the floor where she was monitored and found to be pale and clammy; [provider] was called and then 911 was called when her vital signs were taken and found to be declining." Further review of progress notes failed to reveal documentation that Resident R2's resident representative was notified of her change in condition and transport to the hospital. Review of the "Transfer/Discharge/Bed Hold Form Notice" dated 3/25/2/, at 1:43 p.m. indicated under	F 0580		

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F 0580 SS=E	Continued from page 12 the "Key Contacts" section for staff to review the resident face sheet for contact information. Under the "Bed Hold Notice" section indicated that the resident representative was notified of the bed hold information, but no and for the staff to indicate if the bed hold was elected or not. No documentation of a choice was made. The section to document the name of the resident representative was blank, the phone number for the representative was blank, the date was listed as 2/25/25, at 00:00. The name of the staff member completing the notification was documented as "RN." During an interview on 3/31/25, at approximately 1:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to notify resident representative and/or medical providers of a newly ordered medication or a change in condition for three of seven residents. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 201.29 (d) Resident rights.	F 0580		

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F 0580 SS=E	Continued from page 13 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.	F 0580		
F 0600 SS=G	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 0600	Past noncompliance: no plan of correction required.	Completion Date: **04/23/2025** Status: **APPROVED** Date: **04/25/2025**

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F 0600 SS=G	Continued from page 14 Based on review of facility policies and documents, clinical record review, and staff interview, it was determined that the facility failed to protect residents from neglect that resulted in the actual harm of an elopement for one of two residents (Resident R1). This was identified as past non-compliance. Review of the facility policy "Abuse and Neglect - Clinical Protocol" dated 1/22/25, defined neglect as 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 "Resident Elopement" dated 1/22/25, indicated cognitively impaired residents at risk for elopement will be appropriately monitored to reduce the potential for injury. Elopement is defined as a resident leaving the physical structure of the facility without knowledge of facility staff. Review of the clinical record revealed Resident R1	F 0600		

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WECARE AT MONROEVILLE REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **026102**	**4142 MONROEVILLE BOULEVARD MONROEVILLE, PA 15146**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0600 SS=G	Continued from page 15 was initially admitted to the facility on 2/9/17, and readmitted on 1/29/18. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 1/31/25, included diagnoses Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior), bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior), and a seizure disorder. Review of Section C: Cognitive Patterns revealed Resident R1 had severe cognitive impairment. Review of an "Elopement Risk Assessment" completed on 1/31/25, indicated Resident R1 wandered aimlessly/non-goal directed, that her wandering behavior was likely to affect the safety or well-being of self/others, and concluded that Resident R1 had, "Risk of Elopement, proceed with identification of resident as an elopement risk	F 0600		

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F 0600 SS=G	Continued from page 16 including but not limited to wander guard (electronic monitoring bracelet) placement and facility notification. Proceed to the Care Plan and Initiate." Review of the physician's orders indicated Resident R1 was ordered an electronic monitoring bracelet, initially ordered 2/9/17, continuously reordered, and remains a current order. Review of Resident R1's plan of care for "At risk for elopement related to: Wandering" initiated 8/20/18, undated 8/21/24, included the goal of [Resident R1] will have no incidence of elopement." Review of a late entry progress note dated for 3/12/25, at 3:05 p.m. (created on 3/13/25, at 2:25 p.m.) indicated that the physician was notified of Resident R1's elopement. Further review of Resident R1's progress notes failed to include any other notes on 3/12/25. Review of facility submitted information dated	F 0600		

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F 0600 SS=G	Continued from page 17 3/13/25 by the Director of Nursing (DON), indicated that on 3/12/25, at 5:00 p.m. "[Resident R1] was observed by a Nurse Aide (NA) Employee E1 outside near [Resident R3's room]. Resident was redirected and brought inside by Registered Nurse (RN) Employee E2. RN Supervisor (RNS) Employee E4 immediately performed assessment on resident with no injury noted. At 5:19 (p.m.) Resident R1 was seen in parking lot by RN Employee E3 and redirected to inside of facility. Resident was dressed appropriately. No injuries noted." Review of an undated employee statement written by the DON indicated, "On Wednesday March 12, I had left the building at 3;45 for the day and informed the ADON and RN sup (supervisor). At 4:34 p.m. RN Employee E4 called me and stated there was an elopement. Resident R1 was located outside of a window trying to crawl in. Resident was brought back into the building by NA Employee E1. RN Employee E2 was the med cart nurse, and she was taken back to her. I told RNS Employee E4 to	F 0600		

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F 0600 SS=G	Continued from page 18 set up a 4-point system to mark all exits to be seen and do an immediate census count. I asked if [ADON, Assistant Director of Nursing] was available, the ADON, she stated yes, and would have her call me. Told her she could assist with this and anyone in the building. Asked her to also complete Wanderguard check and function on all elopement residents I called the [NHA, Nursing Home Administrator] to inform him of the elopement, he stated he would contact [Maintenance Director Employee E5] to assist with alarm system check, as the IDT (inter-disciplinary team) text chain did not have a response from him. He stated he would contact him, Maintenance director Employee E5 has responded back in the text chain on phone and system was reset. ADON stated she had assistance from Social Worker Employee E6, Activities Director Employee E7. I had missed a call from RN Employee E3 while on the phone with RNS Employee E4. Reported that Resident R1 was in the parking lot and had returned her safely. I spoke to RNS Employee E4 again and she had all alarms in place, complete census	F 0600		

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F 0600 SS=G	Continued from page 19 done/complete. Resident R1 was safe, would continue 1/2 hour checks on Resident R1 and doors thru the night until safety check done on alarm system." Review of an undated employee statement written by the Human Resources Director (HRD) Employee E8 indicated, "NA Employee E9 began telling me they just brought Resident R1 back into the building 5 minutes ago, Resident R1 was standing outside the window around I asked her if she was brought back to her room. The answer was yes. 4:43 pm, I called and texted DON to confirm. If she was aware of these things happening." I went look for NA Employee E9 was hallway ADON also was texted and called to find her." "As I was looking for I was approached about Resident R3 trying to get out through the lobby around 5:01 pm. ADON told NA Employee E9 to call DON. I was walking toward the lobby when I (saw) that Resident R1 was outside and refused to come in, I ran to side 2 for nursing staff. Everyone was passing trays and told me Resident R1 was in her room. First by Employee	F 0600		

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F 0600 SS=G	Continued from page 20 E10, then by RN Employee E2 the nurse tells me twice she is too busy, and resident is in her room. I again state "no she is not she is outside." I was told "I was late that was earlier" by RN Employee E2. I told all 200 (unit) staff she is in a car being brought back to the facility by RN Employee E3 then someone checked her bed. Resident R1 was brought back safe with RN Employee E3." Review of an undated employee statement written by RN Employee E3 I was driving on Monroeville Blvd, as I was about to enter [facility name/address] I noticed one of the residents, Resident R1, getting into a caravan [license plate number]. I parked my car at the entrance of Wecare Monroeville parking lot got out of my car and began to run towards the van, waving my hands yelling stop, stop, wait as the van was driving away. The caravan stopped and I ran up to the van and motioned my hands to put the window down. The lady that was driving put the window down and I asked her to open the door, and I asked her a second time in a stern voice "open the door" so I could get the resident out of the van. I	F 0600		

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F 0600 SS=G	Continued from page 21 tried to remove the resident from the caravan, and she said no, I am going home. I asked the driver where she was going, the driver stated "East Liberty" [neighborhood approximately 11 miles away]. I told the patient I would take her home to East Liberty and the patient exited the caravan, I walked a patient towards my car, she was very resistant to go with me. As she became aggressive. I tried to sit her on the passenger side of my car and proceeded to call the supervisor, DON and ADON. The supervisor responded, I drove into the parking lot and the supervisor and social worker met me outside in the parking lot to assist with getting the resident back inside the building." Review of an undated employee statement written by RN Employee E2 indicated, "On Wednesday March 12th, I was working the 200's hall. During the resident's first elopement, I was told she was outside by one of the CNA's (nurse aides). Assisted her back into the building. Her Wanderguard was again checked for placement and was present. During her second elopement another resident had a	F 0600		

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F 0600 SS=G	Continued from page 22 choking incident that utilized multiple staff members and again was notified by staff." Review of an undated, handwritten employee statement written by RNS Employee E4 indicated, "RN Employee E2 was assigned as the nurse for Resident R1. She eloped twice on the shift. She did not complete a risk management, vitals, 15 min (minute) checks, head to toe assessment, progress note, did not notify family or Md (Doctor of Medicine). RN Employee E2 was the nurse assigned for 16 hours." Review of an additional typed, undated employee statement with RNS Employee E4's name typed on it stated, "Resident R1 was observed by NA Employee E1 outside near Resident R3's room, the resident was redirected and brought inside by host of staff. Head to toe assessment completed by writer and no injury noted. MD and family notified. At 5:19 Resident R1 was seen in the parking lot by staff RN and redirected to inside of facility by writer and social worker. Head to toe assessment	F 0600		

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F 0600 SS=G	Continued from page 23 completed. No new injuries noted. New Wanderguard placed on L (left) ankle. Door checks put in place. Resident R1 was placed on q 15 min (every 15 minute) checks. ADON spoke to maintance and checked door and Accutech (alarm system) for proper functionality, had her check q (every) door that magnets where locked, and had Wanderguard system check at each door. Maintenance provided an all clear. Family, DON, and physician notified." During a follow-up interview on 3/28/25, at 11:58 a.m. RNS Employee E4 confirmed she had been terminated by the facility for lack of actions related to Resident R1's elopement. RNS Employee E4 stated that the evening had been extremely busy, with two residents attempting to leave, one resident having a choking episode, one resident found to be smoking in the facility, and one resident having a seizure while unattended in the dining room. RNS Employee E4 confirmed that she had delegated the 15-minute checks and risk assessment form to the cart nurse, RN Employee E2.	F 0600		

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F 0600 SS=G	Continued from page 24 During an interview on 3/26/25, at 11:36 a.m. the Director of Nursing confirmed that after Resident R1 was brought back into the facility after her first elopement attempt, RNS Employee E4 was provided direction by the DON to notify the physician and Resident R1's emergency contact, ensure a resident assessment was completed, and have 15-minute checks begun on Resident R1. The DON confirmed that RNS Employee E4 and RN Employee E2 neglected to complete the assessment and the 15-minutes checks, which allowed Resident R1 to exit the facility again, and get into an unknown community members car. The DON and the Nursing Home Administrator confirmed that RN Employee E2 and RNS Employee E4 were terminated from their employment to this negligence of duties. Review of facility provided education documents indicated all facility staff were provided electronic education on abuse and neglect on 3/18/25, with confirmations documented that all staff received and	F 0600		

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F 0600 SS=G	Continued from page 25 understood the provided education. The facility has demonstrated compliance since 3/18/25. During an interview on 3/31/24, at approximately 1:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that RN Employee E2 and RNS Employee E4 were terminated from their employment as of 3/17/25, and confirmed that the facility failed to protect residents from neglect that resulted in the actual harm of an elopement for one of two residents. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa Code 211.12(d)(1)(2)(5) Nursing services.	F 0600		
F 0684 SS=E		F 0684		

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F 0684 SS=E	Continued from page 26 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	Facility is unable to retroactively correct identified notification for R7 blood sugar out of range for dates specified. Physician was made aware of trend in glucoses over this period. Medication was reviewed with physician to ensure order is appropriate. Facility is unable to retroactively correct identified notification for R18 blood sugar out of range for dates specified. Physician was made aware of trend in glucoses over this period. Medication was reviewed with physician to ensure order is appropriate. Facility is unable to retroactively correct identified notification for R19 blood sugar out of range for dates specified. Physician was made aware of trend in glucoses over this period. Medication was reviewed with physician to ensure order is appropriate. Facility is unable to retroactively correct identified notification for R20 blood sugar out of range for dates specified. Physician was made aware of trend in glucoses over this	Completion Date: **05/06/2025** Status: **APPROVED** Date: **04/25/2025**

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F 0684 SS=E	Continued from page 27	F 0684	period. Medication was reviewed with physician to ensure order is appropriate. DON/designee will conduct a facility-wide audit of residents with sliding scale orders to ensure Blood sugar values are reviewed, Documentation of physician notification per ordered parameters, Evidence of follow-up and resident response to abnormal readings. No negative findings. All licensed nursing staff will receive mandatory in-service training by DON on Interpreting provider-specific glucose parameters, Timely physician notification procedures, Documentation expectations, and Diabetes Management Protocol by 4/30/25 DON/designee will conduct audits 5 times per week for 4 weeks, then 3 times per week for 2 weeks on residents emr with blood sugar out of range contains Documentation of	

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F 0684 SS=E	Continued from page 28	F 0684	physician notification per ordered parameters, Evidence of follow-up and resident response to abnormal readings.	

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F 0684 SS=E	Continued from page 29 Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to notify physicians of increased and decreased Capillary Blood Glucose (CBG) levels for four of eight residents (Residents R7, R18, R19, and R20). Findings: Review of the facility policy, "Diabetes - Clinical Protocol" dated 1/22/25, indicated, "The physician will order desired parameters for monitoring and reporting information related to blood sugar management. The staff will incorporate such parameters into the Medication Administration Record (MAR) and care plan. Review of the clinical record revealed Resident R7 was admitted to the facility on 6/14/24. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 3/7/25, included diagnoses of coronary artery disease	F 0684		

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F 0684 SS=E	Continued from page 30 (damage or disease in the heart's major blood vessels) and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) Review of Resident R7's care plan initiated 7/16/24, for diabetes indicated to monitor for hyperglycemia (elevated blood sugar). Review of a physician order dated 6/26/24, indicated "Hypoglycemia Protocol Observe Sign/Symptoms of hypoglycemia as needed if blood glucose is less than 70 mg/dl or ordered low parameter follow Hypoglycemia protocol. NOTIFY md > 400 BLOOD SUGAR. ADDITION OF PROGRESS NOTE" Review of Resident R7's blood sugar record revealed the following elevated blood sugar levels without documentation that the provider was notified: 3/24/25, at 7:44 p.m. - 582.0 mg/dL 3/24/25, at 12:47 p.m. - 500.0 mg/dL	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WECARE AT MONROEVILLE REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **026102**	**4142 MONROEVILLE BOULEVARD MONROEVILLE, PA 15146**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0684 SS=E	Continued from page 31 3/16/25, at 10:24 a.m. - 487.0 mg/dL 3/10/25, at 8:43 p.m. - 600.0 mg/dL 3/09/25, at 11:56 p.m. - 478.0 mg/dL 2/17/25, at 11:41 a.m. - 508.0 mg/dL 1/21/25, at 1:22 p.m. - 64.0 mg/dL 1/13/25, at 7:40 p.m. - 506.0 mg/dL 1/04/25, at 8:25 a.m. - 53.0 mg/dL Review of the clinical record revealed Resident R18 was initially admitted to the facility on 3/30/24, and readmitted on 12/26/24. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 1/16/25, included diagnoses of multiple sclerosis (a disease that affects central nervous system) and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) Review of Resident R18's care plan initiated 4/19/24, for diabetes indicated to monitor for hyperglycemia (elevated blood sugar).	F 0684		

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F 0684 SS=E	Continued from page 32 Review of a physician order dated 3/13/25, indicated Resident R18 received insulin lispro (fast-acting injectable medication to treat diabetes) before meals, the amount based on the blood sugar level at the time of administration. The order indicated for staff to call the MD (Doctor of Medicine) for blood sugar levels greater that 341 mg/dl (milligrams per deciliter). Review of Resident R18's blood sugar record revealed the following elevated blood sugar levels without documentation that the provider was notified: 3/22/25, at 8:26 p.m. - 378.0 mg/dL 3/21/25, at 11:37 a.m. - 348.0 mg/dL 3/21/25, at 8:00 a.m. - 360.0 mg/dL 3/21/25, at 6:04 a.m. - 360.0 mg/dL 3/19/25, at 11:40 a.m. - 357.0 mg/dL 3/15/25, at 7:25 p.m. - 364.0 mg/dL 3/13/25, at 11:51 a.m. - 359.0 mg/dL 3/11/25, at 1:22 p.m. - 405.0 mg/dL 3/11/25, at 9:29 a.m. - 372.0 mg/dL 3/11/25, at 5:49 a.m. - 372.0 mg/dL	F 0684		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0684 SS=E	Continued from page 33 3/10/25, at 7:59 p.m. - 357.0 mg/dL 2/06/25, at 8:24 a.m. - 351.0 mg/dL 2/06/25, at 6:04 a.m. - 351.0 mg/dL Review of the clinical record revealed Resident R19 was admitted to the facility on 2/13/24. Review of the MDS dated 2/4/25, included diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness) and diabetes. Review of Resident R19's care plan initiated 3/4/24, for diabetes indicated to monitor for hyperglycemia. Review of a physician order dated 11/8/24, indicated Resident R19 received Novolog insulin (rapid-acting injectable medication to treat diabetes) before meals and at bedtime, the amount based on the blood sugar level at the time of administration (in addition to 6 units before meals) The order indicated for staff to call the MD (Doctor of Medicine) for	F 0684		

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F 0684 SS=E	Continued from page 34 blood sugar levels greater that 400 mg/dl. Review of Resident R19's blood sugar record revealed the following elevated blood sugar levels without documentation that the provider was notified: 2/23/25, at 4:41 p.m. - 402.0 mg/dL 2/09/25, at 11:12 a.m. - 415.0 mg/dL 1/31/25, at 11:06 a.m. - 427.0 mg/dL Review of Resident R20's clinical admission record indicated that resident was initially admitted to the facility on 6/15/21, and readmitted on 7/21/21. Review of Resident R20's MDS dated 12/27/24, included diagnoses of paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease) and diabetes. Review of Resident R20's care plan initiated 1/29/24, for diabetes indicated to monitor for hypoglycemia (decreased blood sugar).	F 0684		

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F 0684 SS=E	Continued from page 35 Review of Resident R20's blood sugar record revealed the following elevated blood sugar levels without documentation that the provider was notified: 3/24/25, at 9:43 p.m. - 38.0 mg/dL Review of progress notes failed to reveal a reassessment of Resident R20's blood sugar level, or treatment for the low blood sugar. During an interview on 3/31/25, at approximately 1:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to notify physicians of increased and decreased Capillary Blood Glucose levels for four of eight residents. 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	F 0684		

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STATE LICENSE NUMBER: **026102**	

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F 0686 SS=E		F 0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0686 SS=E	Continued from page 37 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	Resident 4 was immediately reviewed to ensure physician orders were entered correctly and wound care was immediately initiated, and all missed treatments were assessed and caught up as appropriate. A skin care note and wound progress documentation were entered retrospectively based on the wound nurse's findings. Resident's care plan was reviewed to ensure accuracy. Resident 5 was immediately reviewed to ensure physician orders were entered correctly and wound care was immediately initiated, and all missed treatments were assessed and caught up as appropriate. A skin care note and wound progress documentation were entered retrospectively based on the wound nurse's findings. Resident's care plan was reviewed to ensure accuracy. DON conducted facility-wide skin audit on all wound treatment orders to ensure Timeliness of wound identification and documentation, Presence of treatment orders in the EMR, Accuracy of TARs and	Completion Date: **05/06/2025** Status: **APPROVED** Date: **04/25/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0686 SS=E	Continued from page 38	F 0686	completion records. House skin sweep conducted to ensure all residents assessed for wounds and ensure treatments are completed per order. No harm was identified in any of these cases. Mandatory in-service training will be held by DON for all licensed nursing staff and wound care coordinators by 4/30/25 on Wound care policies and procedures, Proper and timely EMR documentation of new wounds and associated orders, TAR compliance expectations and treatment completion per physician order. DON/designee will audit all new wound treatment orders to ensure that treatments are being delivered and documented 5 days per week for 4 weeks, then 3 times per week for 2 weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0686 SS=E	Continued from page 39 Based on review of facility policy, clinical records, observation, and interviews with staff, it was determined that the facility failed to make certain residents were provided necessary treatment and services, consistent with professional standards of practice, for a pressure ulcer (PU/PIs- injuries to skin and underlying tissue resulting from prolonged pressure on the skin) for two of five residents (Resident R4 and R5). Findings include: Review of the facility policy "Pressure Ulcer/Skin Breakdown - Clinical Protocol" last reviewed 1/22/25, indicated the physician will order pertinent wound treatments. Review of the clinical record revealed that Resident R4 was initially admitted to the facility 6/2/22, and readmitted on 2/28/25. Review of Resident R4's Minimum Data Set (MDS, periodic assessment of resident care needs) dated	F 0686		

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F 0686 SS=E	Continued from page 40 3/4/25, included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), arthritis (inflammation of one or more joints, causing pain and stiffness), and cancer. Section G: Functional Abilities indicated that Resident R4 required assistance to roll left and right in bed. Review of Resident R4's care plan failed to include a plan of care for risk or actual skin impairment. Review of a physician order dated 3/4/25, indicated, "Licensed Nurse to perform head to toe skin check w/ (with) shower." Review of a "Shower/Skin Observation" dated 3/21/25, indicated a new skin impairment observed. Review of Resident R4's progress notes from 3/21/25, through 3/23/25, failed to include information related to Resident R4's new skin impairment.	F 0686		

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F 0686 SS=E	Continued from page 41 Review of the wound care nurse practitioner note dated 3/24/25, at 10:29 a.m. indicated Resident R4 had a new Stage 2 Pressure Injury on the right buttock and with measurements if 1.9 cm (centimeters) length x 2cm width x 0.1 cm depth. Within the note, the nurse practitioner ordered: -Cleanse wound with warm soap and water - and apply calmoseptine (wound care ointment) TID (three times daily) and as needed. -Protein supplements to promote wound healing Review of Resident R4's physician's orders on 3/27/25, failed to include any orders for the care of the new pressure injury on Resident R4's right buttock, and failed to include an order for a protein supplement for wound healing. Review of Resident R4's Treatment Administration Record (TAR) on 3/27/25, failed to include documentation that Resident R4 had received treatment for his new pressure injury. During an interview on 3/28/25, at approximately	F 0686		

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F 0686 SS=E	Continued from page 42 9:00 a.m. the Assistant Director of Nursing confirmed a new wound was observed on 3/21/25, no interim treatment orders were put in place until Resident R4 was seen by the wound care provider, and that when new orders were placed by the wound care provider, they were not entered into the electronic medical record. Review of the clinical record revealed that Resident R5 was admitted to the facility on 10/17/24. Review of Resident R5's MDS dated 2/3/25, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of the sacrococcygeal (tailbone) area, and the presence of pressure ulcers. Section G: Functional Abilities indicated that Resident R5 required substantial/maximal assistance to roll left and right in bed. Review of Resident R5's care plan initiated on	F 0686		

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F 0686 SS=E	Continued from page 43 11/6/24, for pressure ulcers indicated for staff to administer medications and treatments as ordered. Monitor/document for side effects and effectiveness. Review of a physician order dated 10/19/24, indicated, "Licensed Nurse to perform head to toe skin check w/ (with) shower." Review of a "Shower/Skin Observation" dated 3/19/25, and 3/24/25, indicated no new skin impairments observed. Review of Resident R5's progress notes from 3/17/25, through 3/23/25, failed to include information related to a new skin impairment. Review of the wound care nurse practitioner note dated 3/24/25, at 12:40 p.m. indicated Resident R5 had a new Stage 2 Pressure Injury of the right lower leg. Within the note, the nurse practitioner ordered: -Cleanse with 0.025% Acetic Acid (antimicrobial acid solution) - apply medical grade honey product, ABD pad (highly absorbent dressing that provides	F 0686		

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F 0686 SS=E	Continued from page 44 padding and protection for large wounds), and Kerlix (absorbent rolled bandage) daily. -Protein supplements to promote wound healing. Review of Resident R5's physician's orders on 3/28/25, failed to include any orders for the care of the new pressure injury on Resident R5's right lower leg, and failed to include an order for a protein supplement for wound healing. Review of Resident R5's Treatment Administration Record (TAR) on 3/28/25, failed to include documentation that Resident R5 had received treatment for his new pressure injury. During an interview on 3/28/25, at approximately 3:45 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to make certain residents were provided necessary treatment and services, consistent with professional standards of practice, for a pressure ulcer for two of five residents.	F 0686		

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F 0686 SS=E	Continued from page 45 28 Pa. Code: 201.29(a) Resident Rights. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0686		
F 0689 SS=J	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	Past noncompliance: no plan of correction required.	Completion Date: **04/23/2025** Status: **APPROVED** Date: **04/25/2025**

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F 0689 SS=J	Continued from page 46 Based on facility policy review, clinical and facility record review, facility submitted documents, and staff interviews, it was determined that the facility failed to provide adequate supervision to prevent elopement for one of two residents (Resident R1). This failure created an immediate jeopardy situation for 19 of 91 residents. This was identified as past non-compliance. Review of the facility policy "Resident Elopement" dated 1/22/25, indicated cognitively impaired residents at risk for elopement will be appropriately monitored to reduce the potential for injury. Elopement is defined as a resident leaving the physical structure of the facility without knowledge of facility staff. Review of the clinical record revealed Resident R1 was initially admitted to the facility on 2/9/17, and readmitted on 1/29/18. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 1/31/25,	F 0689		

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	395670	A. BLDG: __00_____ B. WING: _____	03/31/2025

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WECARE AT MONROEVILLE REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **026102**	**4142 MONROEVILLE BOULEVARD MONROEVILLE, PA 15146**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0689 SS=J	Continued from page 47 included diagnoses Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior), bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior), and a seizure disorder. Review of Section C: Cognitive Patterns revealed Resident R1 had severe cognitive impairment. Review of an "Elopement Risk Assessment" completed on 1/31/25, indicated Resident R1 wandered aimlessly/non-goal directed, that her wandering behavior was likely to affect the safety or well-being of self/others, and concluded that Resident R1 had, "Risk of Elopement, proceed with identification of resident as an elopement risk including but not limited to wander guard (electronic monitoring bracelet) placement and facility notification. Proceed to the Care Plan and Initiate." Review of the physician's orders indicated Resident	F 0689		

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F 0689 SS=J	Continued from page 48 R1 was ordered an electronic monitoring bracelet, initially ordered 2/9/17, continuously reordered, and remains a current order. Review of Resident R1's plan of care for "At risk for elopement related to: Wandering" initiated 8/20/18, undated 8/21/24, included the goal of [Resident R1] will have no incidence of elopement." Review of a late entry progress note dated for 3/12/25, at 3:05 p.m. (created on 3/13/25, at 2:25 p.m.) indicated that the physician was notified of Resident R1's elopement. Further review of Resident R1's progress notes failed to include any other notes on 3/12/25. Review of facility submitted information dated 3/13/25 by the Director of Nursing (DON), indicated that on 3/12/25, at 5:00 p.m. "[Resident R1] was observed by a Nurse Aide (NA) Employee E1 outside near [Resident R3's room]. Resident was redirected and brought inside by	F 0689		

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F 0689 SS=J	Continued from page 49 Registered Nurse (RN) Employee E2. RN Supervisor (RNS) Employee E4 immediately performed assessment on resident with no injury noted. At 5:19 (p.m.) Resident R1 was seen in parking lot by RN Employee E3 and redirected to inside of facility. Resident was dressed appropriately. No injuries noted." Review of an undated employee statement written by the DON indicated, "On Wednesday March 12, I had left the building at 3:45 for the day and informed the ADON and RN sup (supervisor). At 4:34 p.m. RN Employee E4 called me and stated there was an elopement. Resident R1 was located outside of a window trying to crawl in. Resident was brought back into the building by NA Employee E1. RN Employee E2 was the med cart nurse, and she was taken back to her. I told RNS Employee E4 to set up a 4 point system to mark all exits to be seen and do an immediate census count. I asked if [ADON, Assistant Director of Nursing] was available, the ADON, she stated yes, and would have her call me. Told her she could assist with this	F 0689		

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F 0689 SS=J	Continued from page 50 and anyone in the building. Asked her to also complete Wanderguard check and function on all elopement residents I called the [NHA, Nursing Home Administrator] to inform him of the elopement, he stated he would contact [Maintenance Director Employee E5] to assist with alarm system check, as the IDT (inter-disciplinary team) text chain did not have a response from him. He stated he would contact him, Maintenance director Employee E5 has responded back in the text chain on phone and system was reset. ADON stated she had assistance from Social Worker Employee E6, Activities Director Employee E7. I had missed a call from RN Employee E3 while on the phone with RNS Employee E4. Reported that Resident R1 was in the parking lot and had returned her safely. I spoke to RNS Employee E4 again and she had all alarms in place, complete census done/complete. Resident R1 was safe, would continue ½ hour checks on Resident R1 and doors thru the night until safety check done on alarm system."	F 0689		

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F 0689 SS=J	Continued from page 51 Review of an undated employee statement written by the Human Resources Director (HRD) Employee E8 indicated, "NA Employee E9 began telling me they just brought Resident R1 back into the building 5 minutes ago, Resident R1 was standing outside the window around I asked her if she was brought back to her room. The answer was yes. 4:43 pm, I called and texted DON to confirm. If she was aware of these things happening." I went look for NA Employee E9 was hallway ADON also was texted and called to find her." "As I was looking for I was approached about Resident R3 trying to get out through the lobby around 5:01 pm. ADON told NA Employee E9 to call DON. I was walking toward the lobby when I (saw) that Resident R1 was outside and refused to come in, I ran to side 2 for nursing staff. Everyone was passing trays and told me Resident R1 was in her room. First by Employee E10, then by RN Employee E2 the nurse tells me twice she is too busy, and resident is in her room. I again state "no she is not she is outside." I was told "I was late that was earlier" by RN Employee E2. I told all 200 (unit) staff she is in a car being brought	F 0689		

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F 0689 SS=J	Continued from page 52 back to the facility by RN Employee E3 then someone checked her bed. Resident R1 was brought back safe with RN Employee E3." Review of an employee statement dated 3/13/25, by Activities Director Employee E7 indicated, "On Wed 3/12/25 I was working and heard someone saying we had an elopement. I came to the front and noticed [Resident R2] in the doorway, and the receptionist trying to tell her she needs to get to her room to have dinner. I then took Resident R2 by the hand and she walked back on the unit. A little bit later, I was getting my things together to leave for the day when I heard staff saying Resident R1 was out front. I went to get a wheelchair, they put her in the chair, and I pushed her to her room and got her sitting on her bed and advised her to eat her dinner. She was calm and agreed to eat. I then took the chair back and helped staff make sure all residents were accounted for." Review of an undated employee statement written by RN Employee E3 I was driving on Monroeville	F 0689		

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F 0689 SS=J	Continued from page 53 Blvd, as I was about to enter [facility name/address] I noticed one of the residents, Resident R1, getting into a caravan [license plate number]. I parked my car at the entrance of Wecare. Monroeville parking lot got out of my car and began to run towards the van, waving my hands yelling stop, stop, wait as the van was driving away. The caravan stopped and I ran up to the van and motioned my hands to put the window down. The lady that was driving put the window down and I asked her to open the door, and I asked her a second time in a stern voice "open the door" so I could get the resident out of the van. I tried to remove the resident from the caravan, and she said no, I am going home. I asked the driver where she was going, the driver stated "East Liberty" [neighborhood approximately 11 miles away]. I told the patient I would take her home to East Liberty and the patient exited the caravan, I walked a patient towards my car, she was very resistant to go with me. As she became aggressive. I tried to sit her on the passenger side of my car and proceeded to call the supervisor, DON and ADON. The supervisor responded, I drove into the	F 0689		

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F 0689 SS=J	Continued from page 54 parking lot and the supervisor and social worker met me outside in the parking lot to assist with getting the resident back inside the building." Review of a community member witness statement indicated, "I was driving home on Wednesday 3/12 and turning right onto Monroeville Blvd at the stoplight around 5:15 p.m. I saw a gold minivan parked on Monroeville Blvd with its hazard lights on and an older woman with tied back gray hair wearing a dark pink shirt standing beside the van on the sidewalk. She was standing between the WeCare sign and the speed limit sign. Another car was parked crooked in the facility driveway, and what appeared to be a staff member was walking towards the older woman. I turned my car around up the street on Caruso Drive back onto Monroeville Blvd and pulled into the facility driveway in front of the crooked car as the staff member was helping put the woman into her car. I asked her if she needed help and who to get for help. She stated to go to the front door and ask for [RN Employee E3's name]. I drove up to the facility	F 0689		

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F 0689 SS=J	Continued from page 55 and was able to tell the receptionist that a resident was down the driveway with a staff member. At that time, staff had come to the front and were notified that a resident was down the driveway with a staff member at that current time. They brought out a wheelchair to the lobby, and were able to transfer the resident into the wheelchair and back into the facility safely. No further questions were asked and no nursing staff acknowledgment, except the staff member who was with the resident outside saying thank you. I left the facility." Review of an undated employee statement written by RN Employee E2 indicated, "On Wednesday March 12th, I was working the 200's hall. During the resident's first elopement, I was told she was outside by one of the CNA's (nurse aides). Assisted her back into the building. Her Wanderguard was again checked for placement and was present. During her second elopement another resident had a choking incident that utilized multiple staff members and again was notified by staff."	F 0689		

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F 0689 SS=J	Continued from page 56 Review of an undated, handwritten employee statement written by RNS Employee E4 indicated, "RN Employee E2 was assigned as the nurse for Resident R1. She eloped twice on the shift. She did not complete a risk management, vitals, 15 min (minute) checks, head to toe assessment, progress note, did not notify family or Md (Doctor of Medicine). RN Employee E2 was the nurse assigned for 16 hours." Review of a second, typed, undated employee statement written by RNS Employee E4 stated, "Resident R1 was observed by NA Employee E1 outside near Resident R3's room, the resident was redirected and brought inside by host of staff. Head to toe assessment completed by writer and no injury noted. MD and family notified. At 5:19 Resident R1 was seen in the parking lot by staff FN and redirected to inside of facility by writer and social worker. Head to toe assessment completed. No new injuries noted. New Wanderguard placed on l (left) ankle. Door checks put in place. Resident R1 was placed on q 15 min (every 15 minute) checks.	F 0689		

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F 0689 SS=J	Continued from page 57 ADON spoke to maintance and checked door and Accutech (alarm system) for proper functionality, had her check q (every) door that magnets where locked, and had Wanderguard system check at each door. Maintenance provided an all clear. Family, DON, and physician notified." During a follow-up interview on 3/28/25, at 11:58 a.m. RNS Employee E4 confirmed she had been terminated by the facility for lack of actions related to Resident R1's elopement. RNS Employee E4 stated that the evening had been extremely busy, with two residents attempting to leave, one resident having a choking episode, one resident found to be smoking in the facility, and one resident having a seizure while unattended in the dining room. RNS Employee E4 confirmed that she had delegated the 15 minute checks and risk assessment form to the cart nurse, RN Employee E2. The NHA and the DON were made aware that an Immediate Jeopardy situation existed for residents on 3/26/25, at 11:36 a.m. and a corrective action	F 0689		

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F 0689 SS=J	Continued from page 58 plan was requested. The Immediate Jeopardy template was provided to the facility administration at 11:45 a.m. On 3/26/25, at 4:29 p.m. an acceptable Corrective Action Plan was received which included the following interventions: 1. Immediate action(s) taken for the resident(s) found to have been affected include: -Facility immediately recovered resident and provided safety. RN assessed resident and provided safety. -Physician and Resident Representative was notified of event. -Wander guard device -checked for placement and function. -All door alarms checked for function and lock mechanism to ensure facility is secure. -Resident care plan reviewed and updated to ensure accurate and appropriate interventions in place. -Witness statements were obtained, and immediate headcount checks completed. -On 3/12/25 Supervisor immediately conducted	F 0689		

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F 0689 SS=J	Continued from page 59 door securement and alarm audit and initiated a 4 point system to monitor doors to ensure security -On 3/12/25 Supervisor posted staff at each door while audit conducted to ensure doors are shut, locked, and alarms are on and functioning -On 3/12/25 DON directed RN supervisor and assigned nurse to ensure Resident receives an assessment, and notify physician and family of incident, as well as ensure resident is monitored to prevent reoccurrence. -On 3/13/25 RN Supervisor immediately performed assessment on the resident for injuries; none noted. -On 3/13/25 Door audits completed to ensure doors are secure every 30 minutes. Door alarm checks are completed to ensure alarms are functioning. -On 3/13/25 New alarms were ordered to ensure that alarm sounds are loud enough to hear. -On 3/13/25, Facility notified the attending physician to report findings and conditions of the resident and the resident's legal representative -On 3/13/24, Documentation of incident in residents record completed	F 0689		

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F 0689 SS=J	Continued from page 60 -On 3/13/25, resident's care plan and orders were reviewed and updated to ensure Wanderguard and exit seeking behaviors addressed in care plan and orders as appropriate -On 3/13 all residents were assessed for Elopement Risk -On 3/13/25, residents newly identified to have potential for elopement had care plans updated with appropriate interventions. -On 3/13, facility-initiated house audit for exit/entry points to ensure alarm function and doors lock appropriately -On 3/13, facility conducted whole house resident head count to ensure accountability of residents. -On 3/13, house audit conducted on resident wanderguard orders to ensure accuracy. -On 3/13, all Wanderguards placed on residents were assessed for function, care plans updated as needed. -On 3/13, Elopement Books were audited to ensure accuracy and placed at each nurses station and reception area. -On 3/17/25- RN Supervisor was provided a	F 0689		

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F 0689 SS=J	Continued from page 61 discipline due to not following DON directive to ensure that Resident was assessed and notifications occurred and documented- RN was terminated due to failing to complete these tasks. -On 3/17/25 Nurse assigned to resident on cart also failed to ensure resident was accounted for and skin checks performed following incident. DON provided discipline to this nurse for failure to complete tasks. Termination resulted. 2. Identification of other residents having the potential to be affected was accomplished by: -All residents in house will be assessed for elopement risk by the Director of Nursing or designee by 3/18/25. -All care plans for residents identified with elopement risks will be reviewed and updated with elopement risks will be reviewed and updated with interventions to prevent elopement by the Director of Nursing or designee by 3/18/25. -All residents identified to be elopement risk will have wanderguard placed and added to Elopement Binder per protocol by 3/18/25.	F 0689		

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F 0689 SS=J	Continued from page 62 -House audit on all doors and exit points will be conducted by Maintenance to ensure that facility is secure and alarms are functional by 3/18/25. -House audit on all wanderguards will be conducted to ensure placement and function by 3/18/25. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: -Facility Director of Nursing or designee will conduct education to all facility staff regarding dementia/behavior in LTC residents, Elopement risk and mitigation, and Elopement Policy and Procedures to include keeping doors secure by 3/21/25. -Education will be completed for all clinical staff on Elopement Risks, Assessments, Care Plans, and Supervision of Residents by the Director of Nursing or designee by 3/21/25. -Elopement Books with identified resident photos will be placed on all nurses' stations in addition to the current one at the receptionist's desk by the Administrator or designee 3/21/25. 4. How the corrective action(s) will be monitored to	F 0689		

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	395670	A. BLDG: __00_____ B. WING: _____	03/31/2025

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F 0689 SS=J	Continued from page 63 ensure the practice will not recur: -Audits will be conducted on all doors/exits by Supervisor twice per shift daily for 4 weeks and then weekly thereafter. -Maintenance Director or designee will conduct daily (twice per shift) audit on doors to ensure secure and alarmed. Audit will remain ongoing. -All new admissions will be reviewed for elopement risks by IDT 5 days per week weeks and ongoing. -Elopement assessments will be audited for compliance by IDT 5 days per week and will remain ongoing. -An Ad Hoc Quality Assurance and Process Improvement Meeting will be held by the Administrator or designee. This plan of correction will be monitored at the Quality Assurance and Process Improvement meeting until such time consistent substantial compliance has been met. Review of facility provided information indicated the facility staged an elopement drill on 3/20/24, at	F 0689		

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F 0689 SS=J	Continued from page 64 11:40 a.m. to familiarize staff with procedures. During staff interviews on 3/26/25, between 1:00 p.m. and 4:00 p.m. NA Employees E12, E13, E14, E15, E16, E17, and E18 and LPN Employee E19 confirmed they received education on the elopement policy, elopement prevention and actions to take in the instance of elopement. During an observation on 3/27/25, at approximately 10:00 a.m. Resident R1's and Resident R2's pictures and information were present in the elopement book at the entrance/exit of the building. Further review of the elopement book with resident charts revealed all residents identified as elopement risks were included in the elopement book. During staff interviews on 3/27/25, between 9:00 a.m. and 11:00 a.m. LPN Employees E20 and E21, RN Employee E22, NA Employees E23 and E24, Occupational Therapy Employee E25, Dietary Employees E26, E27, and E28, Environmental Services Employees E29, E30, and E31, and	F 0689		

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F 0689 SS=J	Continued from page 65 Laundry Employee E32 were provided scenarios to test their knowledge on and confirmed they received education on the elopement policy, elopement prevention and actions to take in the instance of elopement. The Immediate Jeopardy was removed on 3/27/25, at 11:00 a.m. when the action plan implementation was verified. The facility had demonstrated compliance as of 3/18/25. During an interview on 3/31/25, at approximately 1:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide adequate supervision to prevent elopement for one of two residents. This failure created an immediate jeopardy situation for 19 of 91 residents. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(e)(1) Management.	F 0689		

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F 0689 SS=J	Continued from page 66 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa Code 211.12(d)(1)(2)(5) Nursing services.	F 0689		
F 0691 SS=E		F 0691		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0691 SS=E	Continued from page 67 483.25(f) Colostomy, Urostomy, or Ileostomy Care §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0691	As of 03/28/25, colostomy care orders were reviewed and updated in the EMR per order for R5. Ostomy supplies were labeled and stored properly and care plan reviewed. As of 03/28/25, physician orders were clarified and entered per order for R6, The care plan was created and implemented to address ostomy care needs, risks of leakage, and maintenance of skin integrity. Incorrect supplies were removed from the resident's room, and the correct items were provided in clearly labeled original packaging. Central Supply updated the inventory records and verified product-match to orders. A facility-wide audit was completed between for all residents with any type of ostomy (colostomy, ileostomy, or urostomy) to ensure Orders were reviewed for completeness and accuracy, Care plans were reviewed for alignment with physician orders and ostomy type, Supply availability, labeling, and product-match were verified in	Completion Date: **05/06/2025** Status: **APPROVED** Date: **04/25/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0691 SS=E	Continued from page 68	F 0691	resident rooms. No adverse outcomes were identified during the audit. By 4/30/25, DON will conduct education for, all licensed nurses, CNAs, and Central Supply staff on: Ostomy care policy and procedures, to include: Ostomy care protocols per professional standards Matching product types and sizes to orders Updating and referencing care plans before providing care Labeling and organizing ostomy supplies in resident rooms Don/designee will Conduct audits 5 times per week for 8 weeks, then monthly thereafter, of all residents with ostomies to ensure: Product-match between orders, supplies, and usage Proper labeling and organization of supplies Care plan accuracy and staff documentation	

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F 0691 SS=E	Continued from page 69 Based on facility policy review, clinical record review, resident, and staff interviews, it was determined that the facility failed to provide colostomy care and services consistent with professional standards of practice for two of two residents (Resident R5 and R6). Findings include: Review of facility policy "Colostomy/Ileostomy Care" dated 1/22/25, indicated for staff to review the resident's care plan. Review of Resident R5's clinical admission record indicated that resident was initially admitted to the facility on 7/26/24, and readmitted on 10/17/24. Review of Resident R5's Minimum Data Set (MDS, periodic assessment of care needs) dated 2/3/25, included diagnoses of diabetes, Ogilvie's syndrome (dilation of the colon in the absence of an anatomic lesion that obstructs the flow of intestinal contents), and the presence of pressure ulcers. Section H:	F 0691		

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F 0691 SS=E	Continued from page 70 Bladder and Bowel indicated the presence of an ostomy. Review of Resident R5's physician order dated 10/22/24, indicated "Colostomy Appliance: Change wafer [Coloplast-Sensura Mio Convex Light/red stripe]/[16911] and bag [Coloplast-Sensura Mio click high output/red stripe]/[18640] q (every) week and prn (as needed)." Review of plan of care initiated on 8/14/24, for potential to restore function / ileostomy characterized by inability to control bowel movements related to Ogilvie syndrome indicated for staff to change appliance per order. Specifications for the type and size were not included in the care plan. During an interview on 3/28/25, at approximately 11:18 a.m. Registered Nurse Employee E11 confirmed she was unaware of what size appliance and water to use, and that she uses the supplies in Resident R5's room or in the supervisor's office.	F 0691		

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F 0691 SS=E	Continued from page 71 Observation of Resident R5's ostomy supplies at this time revealed bags that were not in a box, without a type or size visible. Review of Resident R6's clinical admission record indicated that resident was admitted to the facility on 1/13/25. Review of Resident R6's MDS dated 2/25/25, included diagnoses of ulcerative colitis (a chronic, inflammatory bowel disease that causes inflammation in the digestive tract), malnutrition, and history of a stroke. Section H: Bladder and Bowel indicated the presence of an ostomy. Review of Resident R6's physician order dated 1/13/25, indicated "Colostomy Appliance: Change wafer [manufacturer]/[product number] and bag [manufacturer]/[product number] q week and prn." Review of Resident R6's plan of care on 3/28/25, failed to include a care plan developed for the presence of an ostomy.	F 0691		

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F 0691 SS=E	Continued from page 72 During an observation on 3/28/25, at 12:45 p.m. of Resident R6's room revealed a box with Coloplast bag 18640 in her room, and an empty box for Coloplast wafer 16911 on the floor. During an interview on 3/28/25, at 1:07 p.m. Central Supply Employee E12 stated that the sizes are present on the shipping receipt from the supplier. Review of an email dated 3/28/25, at 3:59 p.m. indicated Resident R5 utilizes Coloplast wafer 16911 and bag 18640 (which agrees with the order), and Resident R6 Coloplast wafer 10571 and bag 18658 (which does not agree with supplies in Resident R6's room). During an interview on 3/31/25, at approximately 1:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to provide colostomy care and services consistent with professional standards of practice for two of two residents.	F 0691		

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F 0691 SS=E	Continued from page 73 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)(5) Nursing services.	F 0691		
F 0725 SS=E		F 0725		

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F 0725 SS=E	Continued from page 74 483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 0725	Facility failed to have sufficient nursing staff to provide nursing and related services. Residents voiced concerns during the group interview regarding delayed call bell response times, inconsistent medication administration, and missed care (showers, shaving, etc.) due to insufficient staffing. Immediately following the survey exit on 3/28/25, the facility initiated the following corrective actions: Reassessment of current staffing levels and assignment adjustments were completed to prioritize resident care needs, including call bell responsiveness, medication administration, and resident hygiene. Nursing leadership provided direct support to ensure critical resident care needs were met. Nursing assistants were reallocated to high-acuity areas as needed to ensure residents received care timely. All residents in the facility have the	Completion Date: **05/06/2025** Status: **APPROVED** Date: **04/28/2025**

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F 0725 SS=E	Continued from page 75	F 0725	potential to be affected by insufficient staffing. A comprehensive review of staffing levels and resident care delivery for all residents was conducted by the Director of Nursing (DON) and Nursing Home Administrator (NHA) by 4/5/25. Focus areas included: Timeliness of call bell responses. Medication administration times. Resident care delivery (showers, shaving, repositioning, ambulation, etc.). Corrective actions were implemented immediately for any identified concerns, and resident care plans were updated accordingly. All nursing staff received education on 4/7/25 and 4/8/25 regarding: Prioritizing resident care needs. Timely response to call bells. Importance of accurate documentation of care provided. Facility policies on safe staffing and reporting staffing concerns.	

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F 0725 SS=E	Continued from page 76	F 0725	Staffing Review Process: The DON or designee will review staffing levels daily during the clinical morning meeting to assess: Adequacy of staffing for all shifts. Appropriate staff assignment based on resident needs. Coverage plans for any call-offs. Weekend staffing coverage will be reviewed and confirmed by the Administrator or DON by the preceding Friday afternoon each week. The DON or designee will conduct random audits on all shifts, observing: Call bell response times. Medication administration timeliness. Completion of showers and daily care tasks. Audits will be conducted 5 times per week for 4 weeks, then weekly for 2 months, and monthly for 3 months thereafter.	

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F 0725 SS=E	Continued from page 77 Based on review of facility policy, resident observations, 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 ten of 18 residents (Residents R4, R5, R12, R13, R14, R15, R16, R17, R18, and R19). Findings Include: Review of the facility policy "Answering the Call Light" dated 1/22/25, indicated staff will ensure timely responses to the resident's requests and needs. During an observation on 3/26/25, at 3:39 p.m. the call light for Residents R19 was alarming. At this time, six nursing staff members were noted to be seated at the nursing station, without responding. When staff observed the surveyor noting the time, Nurse Aide Employee E13 responded to the call	F 0725		

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F 0725 SS=E	Continued from page 78 light. During an interview on 3/27/25, at 11:10 a.m. Resident R5 when asked if he felt the facility maintained enough staff, Resident R5 responded, "No." Resident R5 stated that call light response time can be long, and further stated they don ' t have enough aides "and the ones they do have are on break half the time." During an interview on 3/27/25, at 11:26 a.m. Resident R4 when stated that he often has late medication and that call lights can take up to an hour for response. During interviews and observations completed on 3/27/25, between 2:30 p.m. to 4:00 p.m. the following was noted: Resident R12 stated call lights can take up to a half hour. Resident R13 stated that there have been times when his call light was not responded to. Resident R14 stated that call lights can take 30-60	F 0725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395670	A. BLDG: __00_____ B. WING: _____	03/31/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0725 SS=E	Continued from page 79 minutes. Resident R15 stated that often half of the time he waits a half hour or longer. Review of a grievance filed on 3/3/25, on behalf of Resident R16 indicated a concern of, "There has only been 1 aide to work shifts. It ' s not fair to patients and the aides. Daughter is not being put to bed until 10:30. Today, 3/3/25, fed daughter breakfast and went back at lunch and she had not been moved, changed, or taken care of. She was put to bed at 9:30 p.m. and has not been touched since 6:30 a.m. because of diaper. Moaned all night due to diaper. They aided work hard but they need more help." Review of a grievance filed on 3/3/25, on behalf of Resident R17 indicated a concern of, "Resident came to my office to say the aide was busy and told her she had to wait until the next shift to be changed." Review of a grievance filed on 3/3/25, on behalf of	F 0725		

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F 0725 SS=E	Continued from page 80 Resident R18 indicated a concern of that the aide didn ' t take the time to listen that he was asking to have his shirt changed and left room. Review of Resident Council concerns indicated: -1/22/25: 3-11 call light response and weekend call light response. -2/19/25: 3-11 call light response and weekend call light response. -3/19/25: call light response. During an interview on 3/31/25, at approximately 1:00 p.m. the Nursing Home Administrator and the Director of Nursing 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 ten of 18 residents 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(6) Management.	F 0725		

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F 0725 SS=E	Continued from page 81 28 Pa. Code: 201.20(a) Staff development. 28 Pa. Code: 211.12(a)(c)(d)(1)(2)(3)(4) Nursing services.	F 0725		
F 0726 SS=D		F 0726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0726 SS=D	Continued from page 82 483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:	F 0726	Resident 11 was immediately assessed and orders reviewed by to ensure appropriate. The incident was reviewed by nursing administration. Resident R11's care plan and diabetic protocol orders were re-reviewed and confirmed to be accurate and appropriate for future hypoglycemic events. A clinical record audit was completed by DON/designee to identify residents with orders for emergency interventions (e.g., glucagon) to ensure that orders are clear for glucose gel vs. glucagon based on response level. A facility-wide mandatory in-service was conducted on by DON/designee for all licensed nurses, focusing on: Recognizing signs and symptoms of hypoglycemia When and how to administer glucagon Contraindications for glucose gel (i.e., unresponsive residents) Immediate documentation and	Completion Date: **05/06/2025** Status: **APPROVED** Date: **04/25/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0726 SS=D	Continued from page 83	F 0726	provider notification Don/ designee will conduct audit on all blood glucose out of range interventions to ensure correct treatment 5 times per week for 4 weeks, then 3 times per week for 2 weeks. All hypoglycemic episodes will be reviewed by the DON to ensure Proper treatment selection based on the resident's responsiveness, Documentation of actions taken.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0726 SS=D	Continued from page 84 Based on a review facility policy, clinical records, and staff interviews, it was determined that the facility failed to assure that licensed nurses displayed the appropriate competencies and skills sets to provide nursing services for one of two residents (Resident R11). Findings include: Review of the facility policy, "Management of Hypoglycemia (low blood sugar)" dated 1/22/25, indicated that "Level 3 hypoglycemia is when a resident has altered mental status and/or physical status requiring assistance for the treatment of hypoglycemia. In the actions listed to take include: 1. Call 911 (in accordance with resident ' s advance directives); 2. Administer glucagon (emergency injectable medicine used to treat severe hypoglycemia); 3. Notify the provider immediately ' Review of the "Facility Assessment" dated 1/1/25, indicated the facility is able to provide care for	F 0726		

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F 0726 SS=D	Continued from page 85 residents with diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of the clinical record indicated Resident R11 was originally admitted to the facility on 9/5/24, and readmitted on 3/7/25. Review of the Minimum Data Set (MDS, mandated assessment of a resident's abilities and care needs) for Resident R11 dated 3/5/25, included diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), chronic kidney disease (gradual loss of kidney function), and diabetes. Review of a physician's order dated 3/1/25, for Glucagon: Inject 1mg (milligram) intramuscularly every 1 hours as needed for hypoglycemia of less than or equal to 70 mg/dl who are unresponsive or cannot swallow. Review of a physician's order dated 3/1/25, for Glucose Gel 40 % (edible dextrose gel) Give 1	F 0726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0726 SS=D	Continued from page 86 applicatorful by mouth every 1 hours as needed for hypoglycemia of less than or equal to 70 mg/dl in patients who are asymptomatic or symptomatic and able to swallow. Review of a physician's order dated 3/8/25, for Glucagon: Inject 1 application intramuscularly every 8 hours for hypoglycemia. Review of a progress note written by Registered Nurse (RN) Employee E33 dated 3/23/25, at 10:45 a.m. indicated, " Res became unresponsive. Son here at bedside. CBG (capillary blood glucose) was 59. 1/2 tube of glucose gel given. Only 1/2 tube because re (resident) was not swallowing and sounded slightly gurling (gurgling). Administered 1 glucagon injection. cbg only came up to 65." During interviews on 3/26/25, Licensed Practical Nurse (LPN) Employee E20, LPN Employee E34, RN Employee E35, LPN Employee E36 were able to correctly answer questions on the appropriate care to give to residents with hypoglycemia, that are	F 0726		

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F 0726 SS=D	Continued from page 87 unresponsive. During an interview on 3/26/25, at approximately 3:45 p.m. LPN Employee E37 when asked to describe the actions to take when a resident has hypoglycemia and is unresponsive, LPN Employee E37 stated she would try "to get them up" (raise their blood sugar) and would give them glucose gel. When asked if glucose gel was appropriate to give to a resident that is unresponsive, LPN Employee E37 corrected herself and stated that she would not give glucose gel. When asked if she would provide any medications to the resident, LPN Employee E37 stated that she would not. During an interview on 3/26/25, at approximately 4:15 p.m. the Director of Nursing provided documentation of a corrective action provided to RN Employee E33 related to "Diabetes protocol with low blood sugar." During an interview on 3/31/25, at approximately 1:00 p.m. the Nursing Home Administrator and the	F 0726		

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F 0726 SS=D	Continued from page 88 Director of Nursing confirmed that the facility failed to assure that licensed nurses displayed the appropriate competencies and skills sets to provide nursing services for one of two residents. 28 Pa. Code: 201.14(1) Responsibility of licensee. 28 Pa. Code: 201.18(a)(3) Management.	F 0726		
F 0842 SS=E		F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0842 SS=E	Continued from page 89 483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 0842	On 03/27/25, the Director of Nursing (DON) reviewed the medical records of Residents R7, R8, and R9. While some late entries existed, it was confirmed that not all physician notifications had been made or documented at the time of abnormal blood glucose results. The physician of record for each resident was contacted and updated on: Past abnormal blood sugar values Current status and any necessary follow-up The residents' plans of care were reviewed and updated to emphasize immediate reporting and documentation expectations for critical blood sugar readings. A facility-wide audit of diabetic residents with orders for sliding scale, was conducted by DON, specifically reviewing: Physician orders for blood sugar parameters, Blood glucose logs (CBG), Progress notes and documentation of provider notification to ensure that orders are followed.	Completion Date: **05/06/2025** Status: **APPROVED** Date: **04/25/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0842 SS=E	Continued from page 90 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842	By 4/30/25, Mandatory in-service training will be conducted by DON/designee for all licensed staff on: Diabetic Protocol, Proper documentation and notification practices. Don/designee will conduct audits 5 times per week for 4 weeks, the 3 times per week for 3 weeks on Verified physician/family notification for out-of-range CBG results, treatments per order.	

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F 0842 SS=E	Continued from page 91 This REQUIREMENT is not met as evidenced by:	F 0842		

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F 0842 SS=E	Continued from page 92 Based on the review of facility policy, observations, clinical records, and staff interviews, it was determined that the facility failed to appropriately document physician notification for three of eight residents (Residents R7, R8, and R9). Findings include: Review of the facility policy, "Charting and Documentation" dated 1/22/25, 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 facility communication between the interdisciplinary team regarding the resident's condition and response to care." Review of a physician order for Resident R7 dated 6/26/24, indicated, "Hypoglycemia Protocol Observe Sign/Symptoms of hypoglycemia as needed if blood glucose is less than 70 mg/dl or	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0842 SS=E	Continued from page 93 ordered low parameter follow Hypoglycemia protocol. NOTIFY md (Doctor of Medicine) > 400 BLOOD SUGAR. ADDITION OF PROGRESS NOTE." Review of Resident R7's blood sugar record revealed the following: 1/23/25, at 5:40 p.m. the blood sugar was documented as 438.0 mg/dL. 2/03/25, at 5:23 p.m. the blood sugar was documented as 416.0 mg/dL. 2/05/25, at 1:27 p.m. the blood sugar was documented as 410.0 mg/dL. 2/16/25, at 7:06 p.m. the blood sugar was documented as 479.0 mg/dL. 2/17/25, at 11:42 a.m. the blood sugar was documented as 408.0 mg/dL. 2/21/25, at 5:27 p.m. the blood sugar was documented as 477.0 mg/dL. 2/26/25, at 6:14 a.m. the blood sugar was documented as 61.0 mg/dL. 3/02/25, at 11:44 a.m. the blood sugar was documented as 438.0 mg/dL.	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395670	A. BLDG: 00 B. WING:	03/31/2025

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WECARE AT MONROEVILLE REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **026102**	**4142 MONROEVILLE BOULEVARD MONROEVILLE, PA 15146**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0842 SS=E	Continued from page 94 3/05/25, at 11:08 a.m. the blood sugar was documented as 427.0 mg/dL. 3/08/25, at 11:22 a.m. the blood sugar was documented as 499.0 mg/dL. 3/10/25, at 11:45 a.m. the blood sugar was documented as 478.0 mg/dL. 3/10/25, at 1:29 p.m. the blood sugar was documented as 503.0 mg/dL. 3/14/25, at 11:52 a.m. the blood sugar was documented as 420.0 mg/dL. 3/15/25, at 5:18 p.m. the blood sugar was documented as 507.0 mg/dL. Review of Resident R7's progress notes indicated late entries for each of the above out-of-range blood sugar levels, created on 3/20/25, by the Director of Nursing (DON), that indicated the physician was notified. Review of the DON's punch report from 1/13/25, through 3/20/25, indicated that the DON was not present in the facility on 1/23/25, 2/16/25, 2/21/25, 3/2/25, 3/5/25, 3/8/25, and 3/15/25.	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0842 SS=E	Continued from page 95 Review of a physician order for Resident R8 dated 3/23/25, indicated, indicated Resident R8 receives Humalog insulin (injectable medication for diabetes), and to notify the physician for blood sugar levels above 341. Review of Resident R8's blood sugar record revealed the following: 3/23/25, at 2:13 p.m. the blood sugar was documented as 581.0 mg/dL. 3/23/25, at 6:14 p.m. the blood sugar was documented as 553.0 mg/dL. 3/23/25, at 9:43 p.m. the blood sugar was documented as 415.0 mg/dL. 3/24/25, at 6:11 p.m. the blood sugar was documented as 449.0 mg/dL. Review of Resident R8's progress notes indicated late entries for each of the above out-of-range blood sugar levels, created on 3/25/25, by the DON, that indicated the physician was notified.	F 0842		

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F 0842 SS=E	Continued from page 96 Review of a physician order for Resident R9 dated 3/23/25, indicated, indicated Resident R8 receives Humalog insulin, and to notify the physician for blood sugar levels above 400. Review of Resident R9's blood sugar record revealed the following: 3/21/25, at 12:06 p.m. the blood sugar was documented as 498.0 mg/dL. 3/21/25, at 8:39 p.m. the blood sugar was documented as 505.0 mg/dL. 3/22/25, at 8:17 a.m. the blood sugar was documented as 555.0 mg/dL. 3/23/25, at 7:28 a.m. the blood sugar was documented as 419.0 mg/dL. Review of Resident R9's progress notes indicated late entries for each of the above out-of-range blood sugar levels, created on 3/26/25, DON, that indicated the physician was notified. During an interview on 3/27/25, the DON confirmed that the late entries were entered based	F 0842		

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F 0842 SS=E	Continued from page 97 on audits completed of the charts. When asked, the DON stated that there is a book at the nurses' station that documents the physician notifications. At this time, the DON was asked to provide that book for inspection. On 3/27/25, at approximately 2:30 p.m. the DON provided a photocopy of a one page, with dates of 3/21/25, through 3/26/25. The documentation included the following notifications: -3/21/25, Resident R9, 498 BS (blood sugar) LPN Employee E38. -3/21/25, Resident R9, 505 BS RN Employee E11. -3/22/25, Resident R9, 550 BS RN Employee E39. -3/24/25, Resident R7, 500 BS, LPN Employee E20. -3/24/25, Resident R7, 501 BS, documented in the medical record by LPN Employee E20. -3/24/25, Resident R7, 582 BS, documented in the medical record by RN Employee E3. -3/25/25, Resident R7, 400 BS, documented in the medical record by LPN Employee E36. -3/26/25, Resident R9, 490 BS, RN Employee	F 0842		

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F 0842 SS=E	Continued from page 98 E22. Review of the facility-provided photocopy revealed all of the above entries were written in the same handwriting. During an interview on 3/31/25, at approximately 1:00 p.m., the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to appropriately document physician notification for three of eight residents. 28 Pa. Code: 211.5(f)(g)(h) Clinical records.	F 0842		
F 0865 SS=E		F 0865		

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F 0865 SS=E	Continued from page 99 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) QAPI Prgm/Plan, Disclosure/Good Faith Attmpt §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and	F 0865	Facility's Quality Assurance Performance Improvement (QAPI) committee failed to maintain compliance with nursing home regulations and ensure that plans to improve the delivery of care Th Facility will maintain a Quality Assurance Performance Improvement (QAPI) plan according to regulation in order to Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. To identify others areas potentially affected the Facility will develop and implement appropriate plans of action to correct quality deficiencies and regularly review and analyze data, including data collected under the QAPI program and data specifically related to monitoring residents with sliding scale orders to ensure Blood sugar values are	Completion Date: **05/06/2025** Status: **APPROVED** Date: **04/28/2025**

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F 0865 SS=E	Continued from page 100 §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:	F 0865	reviewed, Documentation of physician notification per ordered parameters, Evidence of follow-up and resident response to abnormal readings. To prevent this from happening again the Nursing Home Administrator or designee will educate the Interdisciplinary Team and Quality Assurance Performance Improvement (QAPI) Committee to ensure the facility's Quality Assurance Performance Improvement program, and its participants, implement effective systems to correct quality deficiencies and ensure that plans effectively address recurring deficiencies. The Quality Assurance Performance Improvement (QAPI) committee will meet weekly x4 then monthly x2 to ensure plans of correction and audit tools are effective. All licensed nursing staff will receive mandatory in-service training by DON on Interpreting	

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F 0865 SS=E	Continued from page 101 §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions.	F 0865	provider-specific glucose parameters, Timely physician notification procedures, Documentation expectations, and Diabetes Management Protocol by 4/30/25. The facility NHA will Monitor corrections, education, and ongoing monitoring to ensure that plans are effective to address recurring deficiencies. DON/designee will conduct audits 5 times per week for 4 weeks, then 3 times per week for 2 weeks on residents emr with blood sugar out of range contains Documentation of physician notification per ordered parameters, Evidence of follow-up and resident response to abnormal readings. NHA will submit reports to QAPI on compliance of audits. To monitor and maintain ongoing compliance for action plans related to related to providing quality care by monitoring resident blood glucose monitoring and ensuring appropriate interventions are	

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F 0865 SS=E	Continued from page 102 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 0865	implemented. The results from auditing and ongoing monitoring reviewed at the Quality Assurance Performance Improvement meetings will be reviewed by the Regional Clinical Operations Director, to ensure adequate implementation of QAPI plans to maintain ongoing compliance.	

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F 0865 SS=E	Continued from page 103 Based on a review of facility documentation, cited deficiencies from previous surveys, review of plan of correction documentation, and staff interview, it was determined that the facility's Quality Assurance and Performance Improvement (QAPI) program failed to correct previously cited deficiencies. This has the potential to affect 18 of 91 residents. Findings include: Review of the facility policy, "Quality Assurance and Performance Improvement (QAPI) Program" dated 1/22/25, indicated objectives of the QAPI program include providing a means to establish and implement performance improvement projects to correct identified negative or problematic indicators and to establish systems through which to monitor and evaluate corrective actions. The facility's deficiencies and plan of correction for the State Survey and Certification (Department of Health) survey ending 2/28/24, revealed the facility developed a plan of correction that included quality	F 0865		

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F 0865 SS=E	Continued from page 104 assurance systems to ensure the facility maintained compliance with cited nursing home regulations. Review of the plan of correction for the survey ending 3/22/24, revealed the following: - The Director of Nursing (DON) completed a whole house audit of all diabetics on 6/26/24 assure all diabetic residents receiving blood glucose checks, had parameters for physician notification for both high and low blood sugars. - An education will be completed by 7/17/24, for licensed nurses on proper notification and documentation on blood sugars that fall out of established physician parameters for blood glucose levels. - The DON/designee will complete a weekly audit of five residents receiving blood glucose levels to assure that all reading out of parameters have been followed up according to policy and the attending physician has been made aware. This will be done for six weeks.	F 0865		

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F 0865 SS=E	Continued from page 105 - The DON/designee will submit a report to QAPI on the compliance with notification of physicians on high or low blood sugar levels. This will be done for a period of two months. The results of the current survey, ending 3/31/25, identified a repeated deficiency related to the lack of notification of medical providers for out-of-range blood sugar levels for four of eight residents. During the survey process the following was revealed: Review of Resident R7's blood sugar record revealed the following elevated blood sugar levels without documentation that the provider was notified: 3/24/25, at 7:44 p.m. - 582.0 mg/dL 3/24/25, at 12:47 p.m. - 500.0 mg/dL 3/16/25, at 10:24 a.m. - 487.0 mg/dL 3/10/25, at 8:43 p.m. - 600.0 mg/dL 3/09/25, at 11:56 p.m. - 478.0 mg/dL 2/17/25, at 11:41 a.m. - 508.0 mg/dL	F 0865		

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F 0865 SS=E	Continued from page 106 1/21/25, at 1:22 p.m. - 64.0 mg/dL 1/13/25, at 7:40 p.m. - 506.0 mg/dL 1/04/25, at 8:25 a.m. - 53.0 mg/dL Review of Resident R18's blood sugar record revealed the following elevated blood sugar levels without documentation that the provider was notified: 3/22/25, at 8:26 p.m. - 378.0 mg/dL 3/21/25, at 11:37 a.m. - 348.0 mg/dL 3/21/25, at 8:00 a.m. - 360.0 mg/dL 3/21/25, at 6:04 a.m. - 360.0 mg/dL 3/19/25, at 11:40 a.m. - 357.0 mg/dL 3/15/25, at 7:25 p.m. - 364.0 mg/dL 3/13/25, at 11:51 a.m. - 359.0 mg/dL 3/11/25, at 1:22 p.m. - 405.0 mg/dL 3/11/25, at 9:29 a.m. - 372.0 mg/dL 3/11/25, at 5:49 a.m. - 372.0 mg/dL 3/10/25, at 7:59 p.m. - 357.0 mg/dL 2/06/25, at 8:24 a.m. - 351.0 mg/dL 2/06/25, at 6:04 a.m. - 351.0 mg/dL Review of Resident R19's blood sugar record	F 0865		

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F 0865 SS=E	Continued from page 107 revealed the following elevated blood sugar levels without documentation that the provider was notified: 2/23/25, at 4:41 p.m. - 402.0 mg/dL 2/09/25, at 11:12 a.m. - 415.0 mg/dL 1/31/25, at 11:06 a.m. - 427.0 mg/dL Review of Resident R20's blood sugar record revealed the following elevated blood sugar levels without documentation that the provider was notified: 3/24/25, at 9:43 p.m. - 38.0 mg/dL During an interview on 3/31/25, at approximately 1:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that facility failed to maintain an effective Quality Assurance Committee to ensure that the concerns related to the use of elastic bandages were identified, with the potential to affect 18 of 91 residents. 28 Pa. Code 201.18(e)(1) Management.	F 0865		

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F 0865 SS=E	Continued from page 108 28 Pa. Code 201.18(e)(2)(3)(4) Management.	F 0865		
F 0919 SS=E		F 0919		

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	395670	A. BLDG: __00_____ B. WING: _____	03/31/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WECARE AT MONROEVILLE REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **026102**	**4142 MONROEVILLE BOULEVARD MONROEVILLE, PA 15146**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0919 SS=E	Continued from page 109 483.90(g)(1)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by:	F 0919	The three restrooms without emergency call systems (across from the 200-Unit nursing station and the Activities Room) were: Locked and labeled with signage stating "Staff and Visitors Only" to prevent resident access. All remaining resident-accessible restrooms were audited and confirmed to have functioning emergency call cords or buttons. A house audit was completed by Maintenance Director on all public accessible restrooms to ensure that they are locked or had an accessible call bell. NHA/designee will conduct education for the facility maintenance director and assistants on ensuring all public accessible restrooms are locked or had an accessible call bell. NHA/designee will conduct audit to ensure all public accessible restrooms are locked or have an accessible call bell, weekly for three	Completion Date: **05/06/2025** Status: **APPROVED** Date: **04/25/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0919 SS=E	Continued from page 110	F 0919	weeks.	

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F 0919 SS=E	Continued from page 111 Based on review of facility documents, observations and staff interview, it was determined that the facility failed to maintain an effective call system for three of five restrooms accessible to residents. Findings include: Review of the "Facility Assessment" dated 1/1/25, indicated that listed under the "Physical Environment" resources was a nurse call system. During an observation on 3/27/25, at 9:38 a.m. the staff restroom across from the 200-Unit nursing station was observed unlocked, with the door open. Observation of the restroom revealed no emergency call light or call cord attached for emergency use. During an observation on 3/28/25, at approximately 1:00 p.m. the two staff restrooms across from the Activities room were observed unlocked, with the doors open. Observation of the restrooms revealed no emergency call light or call cord attached for	F 0919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0919 SS=E	Continued from page 112 emergency use. During an interview on 3/28/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed the restrooms were unlocked, which allowed access by residents, and confirmed that no call lights were available for resident use in the event of an emergency. During an interview on 3/28/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed the facility failed to maintain an effective call system for three of five restrooms accessible to residents. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (b) (1) Management	F 0919		

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P 3600		P 3600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 3600	Continued from page 1 Utility room. (a) Provisions shall be made in each nursing unit near the nurses ' station for utility rooms. The area shall have separate soiled and clean workrooms. The rooms may not be more than 120 feet from the most remote room served. If one nursing station services several resident corridors, a soiled utility room shall be on each unit. This REGULATION is not met as evidenced by:	P 3600	Facility immediately audited all clean supplies were removed from the soiled utility room. Environmental Services (EVS) deep-cleaned and disinfected the space. Facility evaluated lock on utility room door to ensure function. Currently, lock is functional and door does properly close and lock. Facility conducted a facility-wide audit of all utility rooms to ensure soiled and clean items are separated per requirements. By 4/30/25, all relevant staff (including nursing, maintenance, EVS, therapy, and supply chain) were educated by the Infection Preventionist and DON on: Environmental separation and cross-contamination risks Proper storage and handling of clean and soiled supplies Expectations for utility room use and reporting of noncompliance Facility will install new lock on soiled utility room door. Door closer will be adjusted to ensure positive latching.	Completion Date: **05/06/2025** Status: **APPROVED** Date: **04/25/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 3600	Continued from page 2	P 3600	Nha/designee will perform bi-weekly inspections of all clean and soiled utility rooms for 1 month, then monthly thereafter. Results will be logged and submitted to the QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 3600	Continued from page 3 Based on observations and staff interview, it was determined that the facility failed to provide separate soiled and clean workrooms in one of two utility rooms (Side One soiled utility rooms). Findings include: Review of "28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations, §205.33. Utility room," dated 7/1/23, indicated the following subsection. (a) Provisions shall be made in each nursing unit near the nurses' station for utility rooms. The area shall have separate soiled and clean workrooms. The rooms may not be more than 120 feet from the most remote room served. If one nursing station services several resident corridors, a soiled utility room shall be on each unit. During an observation on 3/27/24, at 12:27 p.m. of the Side One soiled utility room it was noted that the keypad locking mechanism was missing a button,	P 3600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 3600	Continued from page 4 and the door was open approximately two inches. Observation of the room at this time revealed red biohazardous waste bags and black waste bags on the floor, a folded mattress on the floor, what appeared to be used oxygen tubing in the sink, greater than thirty vacutainers, GI, urine, and respiratory collection kits, and blood collection needle sets During an interview on 3/31/25, at approximately 1:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that by storing both clean supplies and soiled waste in the soiled utility room, the facility failed to provide separate soiled and clean workrooms in one of two utility rooms.	P 3600		
P 3620		P 3620		

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P 3620	Continued from page 5 Utility room. (c) Hand-washing facilities shall be available in the soiled and clean utility rooms. This REGULATION is not met as evidenced by:	P 3620	Facility immediately addressed both soiled utility rooms to ensure that Linen hampers blocking sinks in side one and side two rooms were removed and relocated to designated dirty linen holding areas outside of the rooms. The sink in side one was sanitized and cleared of used oxygen tubing, which was disposed of appropriately. Both sinks were disinfected with a facility-approved EPA-registered disinfectant. A facility-wide audit of all clean and soiled utility rooms was conducted by the NHA on ensuring that sinks are accessible and clean and soiled items remain separate as per requirements. By 4/30/25, mandatory clear access to all handwashing sinks in utility rooms and no storage of linen hampers, carts, or other obstructions within 3 feet of a sink, Proper placement and handling of soiled linens and equipment Nha/designee will conduct weekly	Completion Date: **05/06/2025** Status: **APPROVED** Date: **04/25/2025**

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P 3620	Continued from page 6	P 3620	audits of all utility rooms will be conducted to: Verify unobstructed access to all sinks and proper storage and placement of soiled linens and equipment.	

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P 3620	Continued from page 7 Based on observations and staff interview, it was determined that the facility failed to provide hand-washing capabilities in two of two soiled utility rooms (Side One and Side Two soiled utility rooms). Findings include: Review of "28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations, §205.33. Utility room," dated 7/1/23, indicated the following subsection: (c) Hand-washing facilities shall be available in the soiled and clean utility rooms. During an observation on 3/27/24, at 12:27 p.m. of the Side One soiled utility room it had what appeared to be used oxygen tubing in the sink and that access to the sink was blocked by two linen hampers. During an observation on 3/27/24, at 12:33 p.m. of the Side Two soiled utility room it was noted that	P 3620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 3620	Continued from page 8 access to the sink was blocked by six linen hampers. During an interview on 3/31/25, at approximately 1:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that by storing clean supplies in the soiled utility room, the facility failed to provide separate soiled and clean workrooms in one of two utility rooms.	P 3620		

Certified End Page

WECARE AT MONROEVILLE REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 026102

SURVEY EXIT DATE: 03/31/2025

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
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