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:	04/18/2025

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	F 0000		

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.

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: _____	04/18/2025

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F 0000	Continued from page 1 Based on a revisit survey completed on April 18, 2025, it was determined that Wecare At Monroeville Rehabilitation and Nursing Center corrected one deficiency cited during the survey of March 19, 2025, however, has two continuing deficiencies under the requirements of the 28 Pa, Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		

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P 5520		P 5520		

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 5520	Continued from page 1 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	The facility cannot retroactively correct cited deficiencies. The facility will continue to maintain the required ratios and implement a contingency plan if needed by calling in off duty staff, calling sister facilities or utilizing bonuses as needed to ensure sufficient nursing staff. Additionally, the facility will continue to maintain efforts to recruit and retain staff to meet care needs and ensure residents are receiving appropriate care and services. The regional staff educated NHA/DON/ on ensuring sufficient nursing staff to meet residents' needs and ensure that the facility is holding daily staffing meetings. To monitor and maintain ongoing compliance the NHA/DON/scheduler will complete staffing meetings 5x weekly x4 weekly then monthly x2 to ensure sufficient nursing staff.	Completion Date: **05/18/2025** Status: **APPROVED** Date: **05/04/2025**

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 5520	Continued from page 2	P 5520	The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

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 5520	Continued from page 3 Based on a review of staffing documents provided by the facility and staff interview it was determined that the facility failed to provide one nurse assistant (NA) per 10 residents on the day shift on six of seven days (4/11/25 to 4/13/25 and 4/15/25 to 4/17/25) one NA per 11 residents on the second shift on three of seven (4/12/25 to 4/14/25) and one NA per 15 residents on the night shift on four of seven days (4/12/25 to 4/14/25 and 4/17/25) as required. Findings include: A review of facility staffing documents provided by the facility from 4/11/25 through 4/17/25, revealed the facility failed to provide NA on the following shifts as required: Day shift: Date Census Actual hours Hours required	P 5520		

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 5520		P 5520		

Continued from page 4

4/11/25	93	73.00	74.40
4/12/25	92	60.00	73.60
4/13/25	97	48.00	77.60
4/15/25	91	67.00	72.80
4/16/25	92	72.00	73.60
4/17/25	91	67.00	72.80

Evening shift:

Date required	Census	Actual hours	Hours
4/12/25	92	64.00	66.91
4/13/25	97	64.00	70.55
4/14/25	94	62.00	68.36

Night shift:

Date required	Census	Actual hours	Hours
4/12/25	92	48.00	49.07
4/13/25	95	48.00	50.67

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P 5520	Continued from page 5 4/14/25 94 48.00 50.13 4/17/25 91 48.50 48.53 During an interview on 4/18/25 at 3:25 p.m., the Nursing Home Administrator confirmed that the facility failed to provide NA's in the facility on the above shifts as required.	P 5520		
P 5640		P 5640		

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 5640	Continued from page 6 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	The facility cannot retroactively correct cited deficiencies The facility will continue to maintain the required ratios and implement a contingency plan if needed by calling in off duty staff, calling sister facilities or utilizing bonuses as needed to ensure sufficient nursing staff. Additionally, the facility will continue to maintain efforts to recruit and retain staff to meet care needs and ensure residents are receiving appropriate care and services. The regional staff educated NHA/DON/ on ensuring sufficient nursing staff to meet residents' needs and ensure that the facility is holding daily staffing meetings. The RDO educated NHA/DON/ on ensuring sufficient nursing staff and ensuring a minimum of 3.20 PPD. To monitor and maintain ongoing compliance the NHA/DON/scheduler will complete staffing meetings 5x weekly x4	Completion Date: **05/18/2025** Status: **APPROVED** Date: **05/05/2025**

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 5640	Continued from page 7	P 5640	weekly then monthly x2 to ensure sufficient nursing staff. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

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 5640	Continued from page 8 Based on a review of nursing time schedules and staff interview, it was determined that the facility failed to provide a minimum of 3.20 PPD (per patient daily) hours of direct care for each resident on two of seven days (4/12/25 and 4/13/25). Findings include: Review of staffing documents and nursing staff schedules from 4/11/25 through 4/17/25, indicated that the State required PPD minimum hours of 3.20 was not met on the following days: 4/12/25= 2.44 PPD. 4/13/25= 2.81 PPD. During an interview on 4/18/25 at 3:25 p.m. the Nursing Home Administrator confirmed that the facility failed to provide a minimum of 3.20 PPD hours of direct care on the above dates as required.	P 5640		

Certified End Page

WECARE AT MONROEVILLE REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 026102

SURVEY EXIT DATE: 04/18/2025

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