STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395289	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wecare at South Hills Rehabilitation and Nrsg Ctr	201 Village Drive Canonsburg, PA 15317

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and residents' financial account records and staff interview, it was determined that the facility failed to return resident funds within 30 days of discharge/death to the appropriate party for one of five residents sampled (Resident R1 and Resident R2).Findings include: Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses that included cancer, high blood pressure, and diabetes. Review of facility documents revealed Resident R1 expired (passes away) on [DATE], at 6:41 a.m. During an interview on [DATE], at 12:30 p.m. Business Office Employee E1 stated the facility does not handle billing on site, the company uses the third-party company Wellsky. They stated, as of [DATE], Resident R1's responsible party was due a refund of $385.00. Review of an email provided by Business Office Employee E1, indicated Resident R1's family contacted the facility on [DATE], at 12:22 p.m. to inquire about the refund owed. The family had made previous inquiries regarding the refund. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE], with diagnoses that included diabetes, cerebral infarction (blood flow to the brain is obstructed by a blood clot resulting in death of brain cells), and high blood pressure. Review of facility documents revealed Resident R2 expired on [DATE], at 1:15 a.m. During an interview on [DATE], at 12:35 p.m. Business Office Employee E1 stated Resident R2's responsible party was due a refund of $2530.00. They stated the refund was processed on [DATE], by Wellsky. The facility was unable to provide a copy of the check or bank statement showing it was cashed. During an interview on [DATE], at 2:00 p.m., the Business Office Employee E1 verified that Resident R1's and Resident R2's personal funds were not refunded to the family within 30 days of his discharge/death from the facility.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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