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	01/23/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 two of five residents (Resident R11 and R52).Findings: Review of the facility policy, Nursing Care of the Older Adult with Diabetes Mellitus (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) dated 8/27/25, indicated, The provider will order the frequency of glucose monitoring and establish appropriate glycemic targets for individual residents. The policy indicated for the facility to establish provider notification guidelines, and provided examples of possible guidelines. Further review failed to reveal a specific facility protocol. Review of the clinical record indicated Resident R11 admitted to the facility on [DATE]. Review of Resident R11's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 11/9/25, included diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and diabetes. Review of Resident R11's care plan revised on 9/26/24, for Potential for hypo/hyperglycemia (low blood sugar/high blood sugar levels in the blood) failed to include interventions related to physician notification for elevated blood sugar levels. Review of a physician order dated 12/30/25, indicated to inject Basaglar insulin (an injectable medication to treat diabetes) 20 units one time daily. Further review of Resident R11's physician orders failed to reveal an order for blood sugar checks or specific parameters for physician notification. Review of Resident R11's blood sugar record revealed the following elevated blood sugar levels without documentation that the provider was notified:12/31/25, at 7:08 p.m. - 524.0 mg/dL (milligrams per deciliter)01/01/26, at 2:49 a.m. - 499.0 mg/dL01/03/26, at 7:10 p.m. - 434.0 mg/dL01/04/26, at 7:01 p.m. - 402.0 mg/dL01/07/26, at 7:36 p.m. - 498.0 mg/dL01/08/26, at 7:23 p.m. - 430.0 mg/dL01/14/26, at 7:05 p.m. - 453.0 mg/dL01/18/26, at 7:07 p.m. - 486.0 mg/dL01/19/26, at 7:04 p.m. - 463.0 mg/dL01/20/26, at 7:20 p.m. - 482.0 mg/dL01/22/26, at 9:43 p.m. - 494.0 mg/dL Review of the clinical record indicated Resident R52 originally admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident R52's MDS dated [DATE], included diagnoses of epilepsy (disorder of the brain characterized by repeated seizures) and diabetes. Review of Resident R52's care plan initiated 10/19/23, for Potential for hypo/hyperglycemia (low blood sugar / high blood sugar levels in the blood) indicated Accuchecks (blood sugar checks) as ordered, call MD (doctor of medicine) per order/facility protocol. Review of a physician order dated 12/30/25, indicated to inject Lantus insulin (an injectable medication to treat diabetes) 20 units at bedtime. Further review of Resident R52's physician orders failed to reveal an order for blood sugar checks or specific parameters for physician notification. Review of Resident R52's blood sugar record revealed the following elevated blood sugar levels without documentation that the provider was notified:11/15/25, at 9:07 p.m. - 419.0 mg/dL (milligrams per deciliter)12/23/25, at 9:48 p.m. - 404.0 mg/dL01/04/26, at 9:43 p.m. - 482.0 mg/dL During an interview on 1/23/26, (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at approximately 1:30 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 two of five residents. 28 Pa. Code 201.18 (b)(1) Management28 Pa. Code 211.10 (c)(d) Resident care policies28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident council group interview, observations and staff interviews it was determined that the failed to provide a clean, safe, comfortable, and homelike environment for clean public shower areas and equipment for two of two resident shower rooms (B/C and A/E shower rooms), failed to provide a clean, safe, comfortable, and homelike environment for two of four resident hallways (B/C Hallways), and two of two resident lounges B/C and A/E resident lounges).Findings include:Review of the facility policy Homelike environment dated 8/27/25, indicated to provide a safe, clean and comfortable environment. Provide a clean, sanitary, and orderly environment and provide comfortable and safe temperatures between 71 and 81.During a tour on 1/21/26, at 2:20 p.m. with the Nursing Home Administrator the following observations were noted:-B/C shower room had a dark brown/black substance in the grout of the shower's floor, cracked tiles at base of the shower and the wall. Thes shower chairs were soiled with brown residue.-A/E shower room had a metal pin sticking out of stall one's rear wall, had discolored shower grout, the third stall's shower head handle with brown substance. Shower chair with brown residue and rust apparent on all four wheels.During an interview on 1/21/26, at 2:21 p.m. the Nursing Home Administrator confirmed the observations of the B/C and A/E shower rooms and equipment.During a Resident council group interview on 1/21/26, at 1:00 p.m. five out of five residents indicated the resident lounges on each side (B/C and A/E) are too cold in the winter months.During an interview and tour on 1/21/26, at 2:50 p.m. with the Nursing Home Administrator and Maintenance Director Employee the following areas indicated inadequate temperatures:-B/C lounge noted to be blowing cold air. Temperature 58.1 F (Fahrenheit).-room [ROOM NUMBER], the temperature was 68 F.-room [ROOM NUMBER], the temperature was 68.9 F.-room [ROOM NUMBER], the temperature was 65.6 F.-room [ROOM NUMBER], the temperature was 64.7 F.-room [ROOM NUMBER], the temperature was 68.3 F.During an interview on 1/21/26, at 4:00 p.m. the Nursing Home Administrator confirmed the facility failed to provide a clean, safe, comfortable, and homelike environment for two of four resident hallways (B/C Hallways), and two of two resident lounges B/C and A/E resident lounges), and failed to provide clean public shower areas and equipment for two of two resident shower rooms (B/C and A/E shower rooms).28 Pa. code: 201.14 (b) Responsibility of licensee.28 Pa Code: 201.18 (e)(1)(2) Management. 28 Pa Code: 201.29 (a)(c) Resident Rights.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility documentation and staff interview, it was determined that the facility failed to protect a resident from neglect for one of three residents resulting in pain and the need for Xray's to rule out possible injuries/ fractures for one of three residents (Resident R11).Findings include:Review of the facility policy Abuse and Neglect dated 8/27/25, indicated that neglect is the failure of the facility to provide services to a resident that are necessary to avoid physical harm, pain or mental anguish. Review of the clinical record indicated that Resident R11 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's dementia, obstructive uropathy, glaucoma, obesity, lack of coordination, and history of right open repair internal fixation of right hip (ORIF). An MDS (Minimum Data Set- a periodic review of a resident care needs) dated 10/24/25, indicated the diagnoses remained current. An MDS dated [DATE], Section G0110 (bed mobility) indicated bed mobility as total assistance of two staff. Section GG0170 (amount of assistance required to perform task) indicated substantial/maximum assistance for turning left and right in bed. During an interview on 1/21/26, at 10:00 a.m., Nurse Aide (NA) Employee E6 stated that substantial maximum assistance indicated the use of two staff to perform task. During an Interview on 1/21/26, at 10:03 a.m., NA Employee E7 and Licensed Practical Nurse (LPN) Employee E3 stated that substantial maximum assistance indicated the use of two staff to perform task.During an interview on 1/21/26, at 10:10 LPN Employee E5 stated that substantial maximum assistance indicated the use of two staff to perform task.Review of Resident R11's orders identified an order dated 1/16/19, which indicated the use of bilateral enabler bars for positioning for Resident R11.During a clinical record review, a progress note dated 8/22/25, at 8:19 a.m., indicated the nurse had been called into Resident R11's room at 5:10 a.m., to find the resident on the floor on her left side. Review of the facility provided document indicated that Nurse Aide Employee E9 had gone into Resident R11's room to provide incontinence care by herself, turned Resident R11 onto her side. The NA then identified that Resident R11 had had a bowel movement. NA Employee E9 then left Resident R11 on her side to go into the bathroom to wet a towel and Resident R11 rolled out of bed.Review of the facility provided documentation did not include documentation of making certain Resident R11 was protected from neglect as the facility called the physician who ordered Xray's be completed to rule out possible injury/ fracture when Resident R11 complained of pain. The documentation did not include whether or not the enabler bars were being utilized.During an interview of 1/20/26, at 1:58 p.m., the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to protect a resident from neglect for one of three residents resulting in pain and the need for Xray's to rule out possible injuries including fractures for one of three residents (Resident R11).28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(e)(1) Management.28 Pa. Code 201.29(a) Resident rights.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa Code 211.12(d)(1)(2)(5) Nursing services.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, information provided by the facility, clinical records and staff interview, it was determined the facility failed to promptly conduct a thorough investigation to rule out neglect and implement corrective action and submit the results of the completed investigation to the State Survey Agency within five working days of the incident as evidenced by one of three residents reviewed (Resident R11).Findings include:Review of the facility policy Abuse and Neglect dated 8/27/25, indicated that neglect is the failure of the facility to provide services to a resident that are necessary to avoid physical harm, pain or mental anguish. Staff and management will help to identify situations that might constitute neglect. The facility will investigate alleged abuse and neglect to clarify what happened and identify possible causes. Review of the facility policy Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating dated 8/27/25, indicated that all reports of resident abuse including injuries of unknown origin, neglect, etc., are reported to local, state and federal agencies as required and thoroughly investigated by the facility. Findings of the investigation are documented and reported. Review of the clinical record indicated that Resident R11 was admitted to the facility on [DATE], with diagnoses which included Alzheimer's dementia, obstructive uropathy, glaucoma, obesity, lack of coordination, and history of right open repair internal fixation of right hip (ORIF). A Minimum Data Set (MDS- a periodic review of a resident care needs) dated 07/30/25, indicated the diagnoses remained current. Section G0110 (bed mobility) indicated bed mobility as total assistance of two staff. Section GG0170 (indicating the assistance required to perform task) indicated substantial/maximum assistance for turning left and right in bed. During an interview on 1/21/26, at 10:00 a.m., Nurse Aide (NA) Employee E6 stated that substantial maximum assistance indicated the use of two staff to perform task. During an Interview on 1/21/26, at 10:03 a.m., NA Employee E7and Licensed Practical Nurse (LPN) Employee E3 stated that substantial maximum assistance indicated the use of two staff to perform task.During an interview on 1/21/26, at 10:10 LPN Employee E5 stated that substantial maximum assistance indicated the use of two staff to perform task.Review of Resident R11's orders identified an order dated 1/16/19, which indicated the use of bilateral enabler bars for positioning for Resident R11.During a clinical record review, a progress note dated 8/22/25, at 8:19 a.m., indicated the nurse had been called into Resident R11's room at 5:10 a.m., to find the resident on the floor on her left side. Review of the facility provided document indicated that Nurse Aide Employee E9 had gone into Resident R11's room to provide incontinence care by herself, turned Resident R11 onto her side. The NA then identified that Resident R11 had had a bowel movement. NA Employee E9 then left Resident R11 on her side to go into the bathroom to wet a towel and Resident R11 rolled out of bed. The documentation did not include whether or not the enabler bar was in use.Review of the facility provided documentation did not include documentation of making certain Resident R11 was protected from neglect as the facility called the physician who ordered Xray's be completed to rule out possible injury/ fracture when Resident R11 complained of pain.During an interview of 1/20/26, at 1:58 p.m., the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to to promptly conduct a thorough investigation to rule out neglect and implement corrective action and submit the results of the completed investigation to the State Survey Agency within five working days of the incident as evidenced by one of three residents reviewed (Resident R11). 28 Pa. Code 201.14 (c) Responsibility of licensee.28 Pa. Code 201.18 (b)(1) Management.28 Pa. Code 201.29 (a) Resident rights.28 Pa. Code 211.10(d) Resident care policies.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure that the resident and/or their representative received written notice of the facility bed-hold policy at the time of transfer for five of six residents reviewed for hospitalization (Resident R8, R9, R23, R57, and R79). Findings Include: Review of federal regulation S483.15(d) Notice of Bed-Hold Policy, indicated, facilities must provide written information about these policies to residents prior to and upon transfer for such absences. This information must be provided to all facility residents, regardless of their payment source. These provisions require facilities to issue two notices related to bed-hold policies. The first notice could be given well in advance of any transfer, i.e., information provided in the admission packet. Reissuance of the first notice would be required if the bed-hold policy under the State plan or the facility's policy were to change. The second notice must be provided to the resident, and if applicable the resident's representative, at the time of transfer, or in cases of emergency transfer, within 24 hours. It is expected that facilities will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. The notice must provide information to the resident that explains the duration of bed-hold, if any, and the reserve bed payment policy. It should also address permitting the return of residents to the next available bed. Review of facility Bed Hold Policy dated 8/27/25, indicated, Prior to transfers and therapeutic leaves, residents or resident representatives will be informed of the bed-hold and return policy by staff. Review of the clinical record indicated Resident R8 was readmitted to the facility on [DATE]. Review of Resident R6's minimum data set (MDS - periodic assessment of resident care needs) dated 10/24/25, included diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), diabetes, and hemiplegia. Review of a progress note dated 9/4/25, at 1:17 p.m. indicated, Resident sent to [hospital] per MD (doctor of medicine) order. [Spouse] made aware. Further review of Resident R8's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the resident or resident representative upon transfer. Review of the Forms section of the electronic medical record failed to include a Transfer/Discharge/Bed Hold Form completed for this hospital discharge. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of Resident R9'sMDS dated [DATE], included diagnoses of CAD, diabetes, and a seizure disorder. Review of a progress note dated 5/4/25, at 8:51 p.m. indicated, Resident was admitted to [hospital] with pneumonia. Family called and updated. RN (registered nurse) made aware. Review of a progress note dated 6/19/25, at 10:46 a.m. indicated, Family notified of the transfer from dialysis to [hospital]. Review of a progress note dated 8/31/25, at 12:30 p.m. indicated, Resident lethargic, noticeable change in mental status. Unable to eat or take p.o. (oral) meds. POA (power of attorney) aware and wants resident in the ER (emergency room) due to holiday weekend. MD notified. Will send to [hospital] at family request. Review of a progress note dated 1/16/26, at 11:33 p.m. indicated, Condition is worsening transferred to the emergency room for further evaluation and treatment. Further review of Resident R9's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the resident or resident representative upon transfer for 5/4/25, 6/19/25, 8/31/25, and 1/16/26). Review of the Forms section of the electronic medical record failed to include a Transfer/Discharge/Bed Hold Form completed for these hospital discharges.Review of the clinical record indicated Resident R23 was readmitted to the facility on [DATE]. Review of Resident R23's MDS dated [DATE], included diagnoses of chronic obstructive pulmonary disease CKD, high blood pressure, and (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	history of a stroke. Review of a progress note dated 8/7/25, at 8:04 a.m. indicated, During video assess slurred speech and tremors observed. Pt remains A/O (alert and oriented), VSS (vital signs stable). Transfer to ED is warranted D/T (due to) possible neurological event). Further review of Resident R23's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the resident or resident representative upon transfer. Review of the Forms section of the electronic medical record failed to include a Transfer/Discharge/Bed Hold Form completed for this hospital discharge. Review of the clinical record indicated Resident R57 was admitted to the facility on [DATE]. Review of Resident R57's MDS dated [DATE], included diagnoses of COPD, heart failure, and arthritis. Review of a progress note dated 9/14/25, at 6:21 p.m. indicated, Resident stating he wanted to go to the hospital due to increased swelling in his lower leg r/t (related to) cellulitis. MD made aware and order received to send him out. 911 called, ambulance personnel arrived, and resident left the facility via stretcher. Further review of Resident R57's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the resident or resident representative upon transfer. Review of the Forms section of the electronic medical record failed to include a Transfer/Discharge/Bed Hold Form completed for this hospital discharge. Review of the clinical record indicated Resident R79 was admitted to the facility on [DATE]. Review of Resident R79's MDS dated [DATE], included diagnoses of ALS, high blood pressure, and a seizure disorder. Review of a progress note dated 10/22/25, at 12:37 p.m. indicated, Hospice RN came in to assess at this time the resident's respirations were approximately 8 per minute with 10 second periods of apnea. She contacted teh resident's husband who did want her sent out the othe [hospital] for evaluation. Further review of Resident R79's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the resident or resident representative upon transfer. Review of the Forms section of the electronic medical record revealed the Transfer/Discharge/Bed Hold Form completed on 10/22/25, was incomplete with the section that indicated the method of resident or resident representative notification was blank. During an interview on 1/23/24, at approximately 1:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to ensure that the resident and/or their representative received written notice of the facility bed-hold policy at the time of transfer for five of six residents reviewed for hospitalization. 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interviews, it was determined that the facility failed to ensure Minimum Data Set (MDS - a periodic assessment of care needs) accurately reflected the resident's status for two of six residents (Resident R50, and R65).Findings include:The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (periodic assessments of care needs), dated October 2025, indicated the following instructions:Intent: The intent of the items in this section (Section O) is to identify any special treatments, procedures, and programs that the resident received or performed during the specified time periods.O0110: Special Treatments, Procedures, and Programs. Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.Review of the clinical record indicated Resident R50 was admitted to the facility on [DATE].Review of Resident R50's MDS dated [DATE], indicated diagnoses of diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and obstructive sleep apnea (a chronic condition in which the throat muscles relax during sleep and the airway may become partially or fully blocked), and renal insufficiency (a condition in which the kidneys lose the ability to remove waste and balance fluids). Section O0110 G1, Use of a non-invasive mechanical ventilator was documented as not indicated as in use.Review of Resident R50's physician order dated 12/26/25, indicated CPAP with oxygen four liter bleed every evening and night for obstructive sleep apnea.Review of Resident R50's current care plan indicated oxygen at four liters/minute to the CPAP device.Review of Resident R50's treatment administration record dated December 2025 indicated a Bipap was administered from 12/5/25, through 12/25/25.During an interview on 1/20/26, at 1:42 p.m. Resident R50 indicated using the CPAP machine every night.Interview completed on 1/20/26, at 1:42 p.m. The Director of Nursing confirmed Resident R50's MDS did not indicate use of CPAP or Bipap as required and documented as administered on the treatment administration record.Review of the clinical record indicated Resident R65 was admitted to the facility on [DATE].Review of Resident R65's MDS dated [DATE], indicated diagnoses of diabetes, obstructive sleep apnea, and chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness). Section O0110 G1, Use of a non-invasive mechanical ventilator was documented as not indicated as in use.Review of Resident R65's physician order dated 3/27/25, indicated BiPAP use at bedtime for obstructive sleep apnea.Review of Resident R65's current care plan indicated BiPAP sat 91%, exp (expiration)-6, insp (inspiration) - 12 O2 2L bleed, assist with BiPAP as ordered.Review of Resident R65's treatment administration record dated January 2025, indicated a BiPAP was administered from 12/5/25, through 12/25/25.During an interview on 1/21/26, at approximately 11:30 a.m. Resident R65's BiPAP mask was on the floor next to her bed. When asked, Resident R65 stated she tries to use her BiPAP but is unable to put the mask on herself, and the nursing staff, doesn't get in here much to assist in applying the mask.Interview on 1/23/26, at 12:00 p.m. the Director of Nursing confirmed the facility failed to ensure MDS assessments accurately reflected the resident's status for two of six residents.28 Pa. Code 211.12(c)(d)(5) Nursing services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to update a care plan for two of six residents (Residents R50 and R58) to accurately reflect the current status of the resident. Findings include: Review of the facility policy Care Plans, Comprehensive Person-Centered dated 8/27/25, indicated the person-centered care plan describes services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being including services for each element of care. Review of the clinical record indicated Resident R50 was admitted to the facility on [DATE]. Review of Resident R50's Minimum Data Set (MDS- a periodic assessment of care needs) dated 12/9/25, indicated diagnoses of diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), obstructive sleep apnea (a chronic condition in which the throat muscles relax during sleep and the airway may become partially or fully blocked), and renal insufficiency (a condition in which the kidneys lose the ability to remove waste and balance fluids). Section O0110 G3 CPAP (non-invasive treatment for sleep apnea that uses a machine to deliver pressurized air through a mask, keeping the airway open during sleep to prevent breathing pauses) was not indicated as in use. Review of Resident R50's current physician orders included the following medications:-Glargine insulin 28 units subcutaneously (fatty tissue layer between the skin and muscle) for diabetes.-Jardiance 12.5 mg (milligrams) for diabetes.-Eliquis 5mg for anticoagulant (blood thinner).-Bumex 2mg for fluid management.-Flomax 0.4 mg for Benign prostatic hyperplasia (BPH - a common enlargement of the prostate gland in aging men that squeezes the urethra).-Finasteride 5mg for BPH.-Lyrica 50mg for neuropathy (nerve damage causing pain and numbness).-Oxycodone 5-325 mg for pain.-Metoprolol 100mg for high blood pressure. Review of Resident R50's current care plan failed to include goals and interventions for management and monitoring of diabetes, anticoagulants, fluid management, BPH, neuropathy, pain, high blood pressure, and potential for constipation related to oxycodone use. Interview on 1/23/26, at 11:55 a.m. the Director of Nursing confirmed Resident R50's care plan was lacking identified medications and disease processes as required. Review of the clinical record indicated Resident R58 was admitted to the facility on [DATE]. Review of Resident R58's MDS dated [DATE], indicated diagnoses of traumatic brain dysfunction (a disruption in the normal function of the brain), anxiety, depression, and post-traumatic stress disorder (PTSD, mental health condition triggered by experiencing or witnessing a terrifying event). Review of Resident R58's facility diagnosis listing included PTSD, dated 4/28/25. Review of a psychiatry note dated 3/6/25, indicated, [Resident R58] detailed a past event that lead to her TBI (traumatic brain injury) and long hospital stay. She reported severe trauma from the experience, and said she had been diagnosed with PTSD after the event. Often experiences mood swings and depression, as well as hypervigilance and increased anxiety and I feel nervous around other people.Review of further psychiatry notes refer to Resident R58's PTSD diagnosis on 7/14/25, 8/26/25 Review of Resident R58's current care plan failed to include goals and interventions accounting for the resident's past experiences and preferences in order to eliminate and/or mitigate triggers that may cause re-traumatization of the resident. Interview on 1/23/26, at 12:00 p.m. the Director of Nursing confirmed the facility failed to update a care plan for two of six residents (Residents R50 and R58) to accurately reflect the current status of the resident. 28 Pa. Code 211.12(d)(5) Nursing services.

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	395289	A. Building B. Wing	01/23/2026

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

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policies, clinical record reviews, and staff interview, it was determined the facility failed to ensure each resident receives proper treatment and services to maintain hearing abilities for five of eight residents reviewed for hearing (Residents R3, R26, R36, R48 and R23). Findings include:Review of the facility policy Consults Policy and Procedures, dated 8/27/25, indicated to ensure all in-facility consults are timely, clinically indicated and in compliance, the facility nursing staff shall notify the attending provider of the consulting provider's recommendations, review the attending physician's acceptance of the recommendation and monitor the compliance with the recommended treatment.Review of the clinical record indicated Resident R3 had been admitted to the facility on [DATE], with diagnoses which included traumatic brain injury, obesity, stroke and heart fibrillation. An MDS (Minimum Data Set- a periodic review of resident needs) dated 11/4/25, indicated the diagnoses remained current.Review of Resident R3's physician orders dated 4/1/15, through current identified an order dated 12/20/16, indicating that Resident R3 may receive audiology services.Review of Resident R3's clinical record did not include an audiologist assessment being completed in the duration of Resident R3's admission from 4/1/15, through current.Review of the clinical record indicated Resident R26 had been admitted to the facility on [DATE], with diagnoses which included autism, intellectual disabilities, obesity and visual disabilities. An MDS dated [DATE] indicated the diagnoses remained current.Review of Resident R26's physician orders dated 3/20/24, through current identified an order for Resident R26 to receive audiology services.Review of Resident R26's clinical record did not include an audiologist assessment being completed in the duration of Resident R26's admission from 3/20/24, through current.Review of the clinical record indicated that Resident R36 was admitted to the facility on [DATE], with diagnoses which included quadriplegia, seizures, dementia, glaucoma and kidney disease. An MDS dated [DATE], indicated the diagnoses remained current.Review of Resident R36's physician orders dated 5/24/22 through current identified an order dated 5/24/22, indicating that Resident R36 may receive audiology services.Review of Resident R36's clinical record identified audiologist assessment on 9/17/25, identifying impacted cerumen of his left ear and Debrox ear drops to be instilled into left ear to remove cerumen.Review of Resident R36's Medication Administration Record (MAR) dated September 2025, did not include an order for Debrox ear drops as per recommendation.Review of Resident R36's clinical record identified an audiologist assessment again on 10/22/25, which again identified impacted cerumen of his left ear and Debrox drops again for left ear.Review of Resident R36's MAR dated October 2025, did not include an order for Debrox ear drops had been obtained as per recommendation.Review of the clinical record indicated Resident R48 was admitted to the facility on [DATE], with diagnoses which included anoxic brain damage and dementia. An MDS dated [DATE], indicated the diagnoses remained current.Review of Resident R48's physician orders dated 7/21/25, through current identified an order for Resident R48 to receive audiology services.Review of Resident R48's clinical record identified an audiologist assessment on 1/5/26, which identified impacted cerumen of left ear and recommendation of Debrox drops.Review of Resident R48'd MAR dated January 2026, did not include and order for Debrox drops to left ear being obtained as per recommendation. Review of the clinical record indicated Resident R23 had been admitted to the facility on [DATE], with diagnoses which included stage IV kidney disease, schizophrenia and unspecified psychosis. An MDS dated [DATE] indicated the diagnoses remained current.Review of Resident R23's physician orders dated 5/10/24, through current identified an order for Resident R23 to receive audiology services.Review of Resident R23's clinical record identified an audiologist assessment on 9/17/25, which identified impacted cerumen of both ears and (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recommendation of Debrox drops.Review of Resident R23's MAR dated September 2025, did not include an order for Debrox drops as per recommendation.Review of Resident R23's clinical record identified and audiologist assessment on 10/22/25, which identified impacted cerumen of both ears and recommendation of Debrox drops.Review of Resident R23's MAR dated October 2025, did not include and order for Debrox drops as per recommendation.During an interview on 1/22/26, at 10:04 a.m., the Director of Nursing on 1/22/26, at 10:04 a.m., confirmed that facility failed to ensure each resident receives proper treatment and services to maintain hearing abilities for five of eight residents reviewed for hearing (Residents R3, R26, R36, R48 and R23). 28 Pa. Code 211.12 (d) (5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility provided documentation and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision and assistance to prevent accidents for one of three residents (Resident R11).Findings include:Review of the clinical record indicated that Resident R11 was admitted to the facility on [DATE]m with diagnoses which included Alzheimer's dementia, obstructive uropathy, glaucoma, obesity, lack of coordination, and history of right open repair internal fixation of right hip (ORIF). An MDS (Minimum Data Set- a periodic review of a resident care needs) dated 10/24/25, indicated the diagnoses remained current. An MDS dated [DATE], Section G0110 (bed mobility) indicated bed mobility as total assistance of two staff. Section GG0170 How much assistance required to perform task) indicated substantial/maximum assistance for turning left and right in bed. During an interview on 1/21/26, at 10:00 a.m., Nurse Aide (NA) Employee E6 stated that substantial maximum assistance indicated the use of two staff to perform task. During an Interview on 1/21/26, at 10:03 a.m., NA Employee E and Licensed Practical Nurse (LPN) Employee E3 stated that substantial maximum assistance indicated the use of two staff to perform task. During an interview on 1/21/26, at 10:10 LPN Employee E5 stated that substantial maximum assistance indicated the use of two staff to perform task. Review of Resident R11's orders identified an order dated 1/16/19, which indicated the use of bilateral enabler bars for positioning for Resident R11. During a clinical record review, a progress note dated 8/22/25, at 8:19 a.m., indicated the nurse had been called into Resident R11's room at 5:10 a.m., to find the resident on the floor on her left side. Review of the facility provided document indicated that Nurse Aide Employee E9 had gone into Resident R11's room to provide incontinence care by herself, turned Resident R11 onto her side. The NA then identified that Resident R11 had had a bowel movement. NA Employee E9 then left Resident R11 on her side to go into the bathroom to wet a towel and Resident R11 rolled out of bed. The documentation did not include whether or not the enabler bar was in use. Review of the facility provided documentation did not include an investigation to identify why NA Employee E9 attempted to provide care alone when Resident R11 was identified to require assistance of two staff. During an interview of 1/20/26, at 1:58 p.m., the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to make certain Resident R11 received proper assistance and supervision to prevent an accident which resulted in pain and the need for Xray's to rule out injury /fractures for Resident R11. 28 Pa. Code 211.10(c)(d) Resident Care Policies28 Pa. Code 211.12(d)(1)(2)(5) Nursing Services28 Pa. Code: 201.18(b)(1) Management.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to provide prescribed treatment and services related to an implanted venous port (a small implantable device placed under the skin usually in the chest to provide reliable long term venous access) for one of three residents (Resident R73), and failed to properly care for total parenteral nutrition (TPN - a method of delivering essential nutrients - fats, proteins, carbohydrates, electrolytes, and vitamins directly into the bloodstream via an intravenous (IV) catheter, bypassing the digestive system)for one of three residents (Resident R74).Findings include:Review of the facility policy Implanted Venous Port - Accessing dated 8/27/25, indicated to cover needle and access site with transparent sterile dressing when the port is accessed. Label dressing with date, time, and initials of the person who is performing the procedure.Review of the facility policy Total Parenteral Nutrition dated 8/27/25, indicated nursing checks the TPN label with the physician order, checks the pump delivery settings in accordance with the order and documents all.Review of the clinical record indicated Resident R73 was admitted to the facility on [DATE], with the diagnoses of chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe), heart failure (heart doesn't pump blood as well as it should), and high blood pressure.Review of Resident R73's physician order dated 1/18/26, indicated to change venous port dressing weekly.Review of Resident R73's baseline care plan failed to include instructions for the care and management of the venous port.Observation on 1/20/26, at 10:15 a.m. Resident R73 was sitting up in bed with a venous port noted to the left upper chest. The dressing covering the venous port was not labeled or dated as required.Observation and interview on 1/20/26, at 10:30 a.m. Registered Nurse (RN) Employee E2 confirmed the dressing to the venous port was not labeled or dated as required.Review of the clinical record indicated Resident R74 was admitted to the facility on [DATE], with the diagnoses of atrial fibrillation (irregular heart rhythm), heart failure (heart doesn't pump blood as well as it should), and high blood pressure.Review Resident R74's physician order dated 1/16/26, indicated the following:-TPN up at 10:00 p.m. start at 81ml (milliliters) for one hour (until 11:00 p.m.).-TPN at 163 ml for ten hours from 11:00 p.m. until 9:00 a.m.-TPN at 81ml for one hour from 9:00 a.m. to 10:00 a.m.Review of Resident R74's care plan dated 1/19/26, indicated the resident has potential for fluid volumechanges related to TPN as primary hydration source.Observation on 1/20/26, at 9:30 a.m. Resident R74 was lying in bed attached to an IV pump that had a bag of TPN actively infusing. The bag did not have verification checks of the TPN content, a date it was hung, or the initials of the person who administered it as required. Observation and interview on 1/20/26, at 9:35 a.m. Registered Nurse (RN) Employee E2 confirmed the bag did not have verification checks of the TPN content, a date it was hung, or the initials of the person who administered it as required. During an interview on 1/20/26, at 3:00 p.m. the Director of Nursing confirmed the facility failed to provide prescribed treatment and services related to an implanted venous port for one of three residents (Resident R73) and failed to properly care for total parenteral nutrition for one of three residents (Resident R74).28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1)(3) Management.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa. Code 211.12(d)(1)(3) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical record, review of facility policy, interview with staff and residents, it was determined the facility failed to provide tracheostomy care consistent with professional standards of practice for one resident with a tracheostomy (Resident R25), and failed to provide appropriate respiratory care and maintain respiratory equipment for five of five residents (Resident R25, R41, R50, R65, and R74). Findings include: Review of the facility policy Tracheostomy Care dated 8/27/25, indicated a replacement tracheostomy tube (a hollow tube inserted into a surgical opening in the neck (stoma) directly into the windpipe to provide long-term ventilation) must be available at the bedside at all times. A suction machine must be available at the bedside at all times. Review of the facility policy Departmental (Respiratory Therapy) - Prevention of Infection last reviewed on 8/27/25, indicated that considerations related to oxygen administration include change the oxygen cannula and tubing every seven days or as needed. Keep the oxygen and tubing used as needed in a plastic bag when not in use. Considerations related to medication nebulizers/continuous aerosol include store the circuit in a plastic bag, marked with date and resident's name, between uses. Discard the administration set up every seven days. Review of the facility policy CPAP/BiPap Support dated 8/27/25, indicated Continuous Positive Airway Pressure (CPAP-keeps airways open when you sleep) or Bilevel Positive Airway Pressure (BIPAP-normalizes breathing by delivering pressurized air)are to be labeled with room number/bed and to be stored in a plastic bag when not in use. Review of the admission record indicated R25 was admitted to the facility on [DATE]. Review of Resident R25's Minimum Data Set (MDS- a periodic assessment of care needs) dated 12/28/25, indicated the diagnoses of chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe), anxiety, and hip fracture. Section O - E1 indicated that resident received tracheostomy care. Review of Resident R25's current physician orders failed to include the type and size of tracheostomy tube. Review of Resident R25's care plan dated 11/21/25, indicated resident will be free from infection related to tracheostomy and failed to include the type and size of tracheostomy tube. Observation on 1/20/26, at 9:30 a.m. Resident R25 was resting in bed with a tracheostomy tube visible and connected to oxygen. A suction cannister was at the bedside with a date that read 12/10/25. The cannister was half full of white/light yellow substance. Observation and interview on 1/20/26, at 9:35 a.m. Registered Nurse (RN) Employee E2 confirmed there was not an order or care plan for the type and size of tracheostomy tube and that the suction cannister had not been changed since 10/10/25. Review of the admission record indicated R41 was admitted to the facility on [DATE]. Review of Resident R41's MDS dated [DATE], indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), high blood pressure, and depression. Review of Resident R41's physician orders dated 11/9/25, indicated to change oxygen tubing weekly and label with date. Also apply water bottle and change it weekly to humidify oxygen. Write date on bottle. Review of Resident R41's current care plan indicated to change respiratory equipment as ordered. Observation on 1/20/26, at 9:20 a.m. Resident R41 was observed with eyes closed sleeping in bed. The oxygen bottle or tubing was dated as required. Interview on 1/20/26, at 9:25 a.m. RN Employee E2 verified the oxygen bottle and tubing were not dated as required. Review of the clinical record indicated Resident R50 was admitted to the facility on [DATE]. Review of Resident R50's MDS dated [DATE], indicated diagnoses of diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and obstructive sleep apnea (a chronic condition in which the throat muscles relax during sleep and the airway may become partially or fully blocked), and renal insufficiency (a condition in which the kidneys lose the ability to remove waste and balance (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fluids). Section O0110 G3 CPAP (non-invasive treatment for sleep apnea that uses a machine to deliver pressurized air through a mask, keeping the airway open during sleep to prevent breathing pauses) was not indicated as in use. Review of Resident R50's physician order dated 12/26/25, indicated CPAP with oxygen four liter bleed every evening and night for obstructive sleep apnea. Review of Resident R50's current care plan indicated oxygen at four liters/minute to the CPAP device. Observation on 1/20/26, at 9:30 a.m. Resident R50's CPAP mask was hanging off the bedside stand not contained in a bag as required. Interview on 1/20/26, at 9:30 a.m. RN Employee E2 verified the CPAP mask was not stored in a bag as required when not in use. Review of the clinical record indicated Resident R74 was admitted to the facility on [DATE], with the diagnoses of atrial fibrillation (irregular heart rhythm), heart failure (heart doesn't pump blood as well as it should), and high blood pressure. Review Resident R74's physician order dated 1/16/26, indicated CPAP unit with 2-liter bleed in of oxygen at night every evening shift. Review of Resident R74's current care plan indicated resident will be compliant with use of CPAP. Observation on 1/20/26, at 9:35 a.m. Resident R74 was out of bed. On the bedside stand was the CPAP mask, not stored in a bag as required. Interview on 1/20/26, at 9:35 a.m. RN Employee E2 verified the CPAP mask was not stored in a bag as required when not in use.Review of the clinical record indicated Resident R65 was admitted to the facility on [DATE].Review of Resident R65's MDS dated [DATE], indicated diagnoses of diabetes, obstructive sleep apnea, and chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness). Section O0110 G1, Use of a non-invasive mechanical ventilator was documented as not indicated as in use.Review of Resident R65's physician order dated 3/27/25, indicated BiPAP use at bedtime for obstructive sleep apnea.Review of Resident R65's current care plan indicated BiPAP sat 91%, exp (expiration)-6, insp (inspiration) - 12 O2 2L bleed, assist with BiPAP as ordered.Review of Resident R65's treatment administration record dated January 2025, indicated a BiPAP was administered from 12/5/25, through 12/25/25.During an interview on 1/21/26, at approximately 11:30 a.m. Resident R65's BiPAP mask was on the floor next to her bed. When asked, Resident R65 stated she tries to use her BiPAP but is unable to put the mask on herself, and the nursing staff, doesn't get in here much to assist in applying the mask.Further discussion revealed that the current mask used is uncomfortable for Resident R65. Resident R65 stated that she has not been provided with options for other types of masks to increase comfort and compliance. Interview on 1/20/26, at 3:00 p.m. the Director of Nursing confirmed the facility failed to provide tracheostomy care consistent with professional standards of practice for one resident with a tracheostomy (Resident R25) and failed to provide appropriate respiratory care and maintain respiratory equipment for five of five residents (Resident R25, R41, R50, R65, and R74). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(c)(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review and staff interviews, it was determined that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for two of four residents (Resident R7 and R33). Findings include: Review of the facility policy Trauma Informed Care and Culturally Competent Care dated 8/27/25, indicated the purpose is to address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Review of the admission record indicated Resident R7 admitted to the facility on [DATE]. Review of Resident R7's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/10/25, indicated the diagnoses of post-traumatic stress disorder (PTSD - a psychiatric disorder that may occur in persons that have witnessed a traumatic event causing intense, disturbing thoughts and feelings related to the experience), dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), and high blood pressure. Section I6100 indicated PTSD is present. Review of Resident R7's current care plan indicated the resident uses psychotropic medications related to vascular dementia and PTSD. The care plan failed to have a traumatic informed care plan addressing the PTSD or identifying potential triggers and prevention for re-traumatization. During an interview on 1/21/26, at 2:30 p.m. the Director of Nursing confirmed the care plan failed to have a traumatic informed care plan addressing the PTSD or identifying potential triggers and prevention for re-traumatization. Review of the admission record indicated Resident R33 admitted to the facility on [DATE]. Review of Resident R33's MDS dated [DATE], indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), heart failure (heart doesn't pump blood as well as it should), and high blood pressure. Interview on 1/22/26, at 11:30 a.m. Resident R33's Legal Guardian indicated that Resident R33 has a history of being victimized by predators involving cellular phone usage. Review of the resident's care plan and clinical record failed to identify this past trauma. Interview with the Director of Nursing on 1/22/26, at 1:00 p.m. indicated that the facility was unaware of Resident R33's traumatic history of being victimized by predators and did not have a plan in place to have a traumatic informed care plan addressing the PTSD or identifying potential triggers and prevention for re-traumatization. Interview on 1/22/26, at 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for two of four residents (Resident R7 and R33). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to conduct accurate assessments to ensure that bedrails were used to meet residents' needs and the risks associated with bedrail usage for one of two residents (Residents R78).Findings include:Review of facility policy Bed Safety and Bed Rails dated 8/27/25, indicated the use of bed rails or side rails is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. Review of the clinical record indicated Resident R78 was admitted to the facility on [DATE], with diagnoses that include Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), bipolar (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and paralytic syndrome (rapid onset of paralysis).Review of Resident R78's physician order dated 1/19/26, indicated bilateral grab bars to bed (used to assist residents to position self in the bed).During an observation on 1/20/26, at 9:15 a.m. Resident R78's bed did not have bilateral grab bars as ordered.Review of Resident R78's care plan dated 1/19/26, indicated bilateral grab bars to bed.Review of Resident R78's Enabler Bar assessment dated [DATE], indicated bilateral grab bars recommended for use by therapy department. The Nursing portion of the assessment was blank.Interview on 1/20/26, at 9:20 a.m. Resident R78 indicated the facility promised to provide side rails to assist self-positioning in bed and resident still did not have them.Interview on 1/20/26, at 9:25 a.m. Registered Nurse (RN) Employee E2 confirmed Resident R78's bed failed to have grab bars bilaterally as ordered and that the facility failed to conduct accurate assessments to ensure that bedrails were used to meet residents' needs and the risks associated with bedrail usage for one of two residents (Residents R78).28 Pa. Code: 201.14 (a) Responsibility of licensee.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)(3)(5) Nursing services.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident clinical records, and staff interviews, it was determined that the facility failed to ensure a resident received appropriate behavioral health services to maintain the highest practicable well-being for one of two sampled residents (Resident R33).Findings include:Review of the facility policy Behavioral health Services dated 8/27/25, indicated behavioral health services are provided to residents as needed as part of the interdisciplinary, person-centered approach to care.Review of the admission record indicated Resident R33 admitted to the facility on [DATE].Review of Resident R33's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/14/26, indicated the diagnoses of heart failure (heart doesn't pump blood as well as it should), anxiety, and depression.Review of Resident R33's current care plan indicated resident has a behavior problem of requesting staff to purchase gift cards for an online friend and requesting staff take her to the store to purchase gift cards related to intellectual disability and poor safety awareness.Interview with Resident R33 on 1/22/26, at 10:00 a.m. indicated the Legal Guardian took the resident's personal cell phone a few weeks ago and resident hasn't had their private therapy call for two weeks now.Interview with Director of Nursing (D0N) 1/22/26, at 11:20 a.m. indicated Resident R33 has a private therapy call every Monday at 1:00 p.m. for as long as the DON has worked at the facility. Resident R33 has missed two therapy appointments because the facility did not have the private therapist's name or number because the Legal Guardian took the phone for repairs and has not returned it.Further interview with the DON on 1/22/26, at 11:50 a.m. revealed the facility did not have the contact name and number of the resident's therapist and indicated the facility has not reached out to the Legal Guardian in attempt to retrieve the therapist's name and number to continue Resident R33's weekly calls from a facility phone for their therapy. During an interview on 1/22/26, at 3:00 p.m. the Director of Nursing confirmed that Resident R33 missed two therapy treatment calls and that the facility failed to ensure a resident received appropriate behavioral health services to maintain the highest practicable well-being for one of two sampled residents (Resident R33).28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1)(3)(e)(1) Management28 Pa. Code 211.12(c)(d)(3) Nursing services28 Pa. Code 211.16(a) Social services

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility policy, resident interviews, clinical records, and staff interview, it was determined that the facility failed to make certain that residents are free of significant medication errors for one of five residents observed (Resident R73).Findings include:Review of the facility policy Adverse Consequences and Medication Errors dated 8/27/25, indicated a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional providing services. Examples include omission - a drug is ordered but not administered.Review of the clinical record indicated Resident R73 was admitted to the facility on [DATE], with the diagnoses of chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe), heart failure (heart doesn't pump blood as well as it should), and high blood pressure.Review of Resident R73's physician order dated 1/17/26, indicated Xanax 0.5 mg (an anti-anxiety medication -milligrams) three times a day for anxiety.Review of Resident R73's Medication Administration Record (MAR) indicated the Xanax was not administered as ordered.Provider note dated 1/18/26, indicated resident was admitted to facility on 1/18/26, was sent back to the hospital that evening due to crushing chest pain and tachycardia (heart rate greater than 100 beats/minute). Resident was treated with one dose of IV lasix (intravenous diuretic) to help with breathing. CTA (computed tomographic angiography) negative for acute pulmonary emboli (blood clot in the lung). Lab work was within normal limits. Of note, due to awaiting pharmacy patient did not have their medications at the facility. He was transferred back to the facility later that night.Observation of Resident R73 on 1/20/26, at 9:15 a.m. indicated resident complaining of nausea and feeling shaky.Interview on 1/20/26, at 9:15 a.m. Registered Nurse (RN) Employee E2 indicated Resident R73 did not receive the physician ordered Xanax as prescribed and that RN felt Resident R73 was experiencing symptoms of withdrawal after long history of receiving the Xanax three times a day.Interview on 1/20/26, at 9:15 a.m. Resident R73 indicated they only received the Xanax twice since being at the facility.Interview on 1/23/25, at 12:00 p.m. the Director of Nursing confirmed that facility failed to make certain that residents are free of significant medication errors for one of five residents observed (Resident R73).28 Pa Code: 211.10 (d) Resident care policies.28 Pa. Code 211.12 (c)(1)(3) Nursing Services.28 Pa Code: 201.18 (b)(1)(3) Management.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to store medications properly, for one of two medication carts (A side medication cart).Findings include:Review of the facility policy Storage of Medications dated 8/27/25, indicated the facility stores all drugs and biologicals in a safe, secure, and orderly manner.During an observation on 1/20/26, at 2:58 p.m. the A side medication cart indicated the following medications opened and not dated as required:-Budesonide inhalation suspension (medication that reduces airway inflammation)-Ipratropium bromide (medication that acts as a bronchodilator) - two boxes-Trelegy Ellipta (medication that's inhaled to treat chronic respiratory illness)-Lantus insulin pen (long-acting insulin used to regulate blood sugar)Interview on 1/20/26, at 2:58 p.m. Registered Nurse (RN) Employee E2 confirmed the medications listed were opened and not dated as required.Interview on 1/20/26, at 3:00 p.m. the Director of Nursing confirmed that the facility failed to store medications properly, for one of two medication carts (A side medication cart).28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(c)(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on staff interview it was determined that the facility failed to employ a qualified Food Service Director to manage the daily operations of the Dietary Department for 12 out of 12 months (February 2025 through January 2026).Findings include:During an interview on 1/20/26, at approximately 9:00 a.m., the Dietary Supervisor Employee E8 stated she was not certified and that the Dietician only works two days a week in the facility and another two days in another facility.During an interview on 1/20/26, at 11:20 a.m., the Nursing Home Administrator stated that the Registered Dietitian (RD) was not employed full time she comes two times a week.During an interview on 1/20/26, 11:20 a.m., the Nursing Home Administrator (NHA) confirmed that the facility failed to provide documented evidence that Dietary Supervisor Employee E8 met the qualifications for the position of Food Service Director. Pa Code: 201.18(e)(6) Management.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on a review of facility policy, observations and staff interview it was determined that the facility failed to properly store food products in the Main Kitchen, which created the potential for foodborne illness.Findings include:Review of the facility policy Food Storage, dated 8/27/25, indicated that food shall be stored to facilitate thorough cleaning, and areas will be maintained in a clean, safe sanitary manner. A thermometer is available in a storeroom, freezer and refrigerator units. During an observation on 1/20/26, from 8:50 a.m., through 9:15 a.m., the following was observed:The drink/food line cooler did not have an internal thermometer. The refrigerator and deep freezer had food stored approximately 3 inches from the ceilings During an interview on 1/20/26, at 9:15 a.m., the Dietary Supervisor Employee E8 confirmed that the facility failed to properly store food products in the Main Kitchen, which created the potential for foodborne illness. Pa. 28 Code: 211.6(c)(d)(f) Dietary services.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on review of facility documents, clinical records, and staff interview, it was determined that the facility failed to make certain that medical records on each resident are complete and accurately documented for of four of nine residents (R8, R18, R46, and R57).The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set Assessments (MDS - periodic assessment of care needs) dated October 2025, indicated that Section C: Cognitive Patterns, Question C0100 Should Brief Interview for Mental Status Be Conducted? (BIMS) should be coded as 0 if the resident is rarely/never understood, or it should be coded 1, and the BIMS assessment should be completed if the resident is at least sometimes understood. The BIMS total score suggests the following distributions:13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of Resident R8's previous BIMS assessments revealed the following:02/05/25: 1403/31/25: 1405/06/25: 1407/28/25: 1410/23/25: 15 Review of Resident R8's BIMS assessment completed on 1/19/26, by Licensed Practical Nurse (LPN) Employee E6, documented that Resident R8 was rarely/never understood, and coded Resident R8 as 0.0 severe impairment. Review of Resident R18's previous BIMS assessments revealed the following:01/21/25: 1504/14/25: 1505/05/25: 1506/09/25: 1510/20/25: 15 Review of Resident R18's BIMS assessment completed on 1/19/26, by LPN Employee E6, documented that Resident R18 was rarely/never understood, and coded Resident R18 as 0.0 severe impairment. Review of Resident R46's previous BIMS assessments revealed the following:02/05/25: 1105/05/25: 1207/28/25: 1510/20/25: 15 Review of Resident R46's BIMS assessment completed on 1/19/26, by LPN Employee E6, documented that Resident R46 was rarely/never understood, and coded Resident R46 as 0.0 severe impairment. Review of Resident R57's previous BIMS assessments revealed the following:02/02/25: 1505/02/25: 1507/28/25: 1510/20/25: 15 Review of Resident R57's BIMS assessment completed on 1/19/26, by LPN Employee E6, documented that Resident R57 was rarely/never understood, and coded Resident R57 as 0.0 severe impairment. During an interview on 1/21/26, at 12:50 p.m. LPN Employee E6 confirmed that Residents R8, R18, R46, and R57 are alert and oriented. LPN Employee E6 confirmed that she incorrectly completed the BIMS assessments completed on 1/19/26. During an interview on 01/23/26, at approximately 1:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed failed to make certain that medical records on each resident are complete and accurately documented for of four of nine residents. 28 Pa. Code: 211.5(f)(g)(h) Clinical records.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility admission documents and staff interview, it was determined that the facility failed to ensure resident rights to make informed decisions and choices in the residents' welfare by making certain residents understand the conditions of a binding arbitration agreement and failed to ensure the agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands for two of five residents (Resident R27 and R48).Findings include: Review of the Resident Assessment Instrument 3.0 User ' s Manual effective October 2025 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:13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of the facility's admission packet contained the document Alternative Dispute Resolution Agreement Between Resident and Facility, indicated With the exception of payment disputes, all other disputes are governed by this agreement, and each of the parties is giving up his/her/its right to resort to the courts and further indicated Binding arbitration means that the parties are waiving their right to a trial, including their right to a jury trial, their right to trial by judge and their right to appeal the decision of the arbitrator(s) except as provided for under applicable state and/or federal laws governing arbitration. Review of Resident R27's admission record indicated the resident was admitted to the facility on [DATE]. Review of Resident R27's admission assessment dated [DATE], indicated that Resident R27 was alert and oriented to person only. Review of Resident R27's baseline care plan dated 1/2/26, indicated that Resident R27 cannot communicate easily with staff and has cognitive needs. Review of a BIMS assessment completed on 1/2/26, revealed Resident R27's score to be 3. Review of Resident R27's admission paperwork indicated all sections, including the Alternative Dispute Resolution Agreement Between Resident and Facility, were signed by Resident R27. Review of Resident R48's admission record indicated the resident was admitted to the facility on [DATE]. Review of Resident R48's admission assessment dated [DATE], indicated that Resident R48 was alert and oriented to person only. Review of Resident R48's baseline care plan dated 7/21/25, indicated that Resident R48 was, very confused, agitated and yelling out. Review of a BIMS assessment completed on 7/22/25, revealed Resident R48's score to be 2. Review of Resident R48's admission paperwork indicated all sections, including the Alternative Dispute Resolution Agreement Between Resident and Facility, were signed by Resident R48. During an interview on 1/23/36, at approximately 1:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to ensure resident rights to make informed decisions and choices in the residents' welfare by making certain residents understand the conditions of a binding arbitration agreement and failed to ensure the agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands for two of five residents. 28 Pa. Code 201.24 (b) admission Policy 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(2) Management 28 Pa. Code 201.29(a)(j) Resident Rights

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, observations, and staff interviews, it was determined that the facility failed to maintain infection control practices to prevent the potential for cross contamination while during wound care for one of six residents (Resident R8), failed to maintain two ice machines in a sanitary manner (A/E wing and B/C wing ice machines), failed to properly monitor residents in room personal refrigerator temperatures for two of two residents (Residents R33 and R64) which created the potential for food borne illness and failed to follow Enhanced Barrier Precautions (EBP) for one of eight residents (Resident R6).Findings include: Review of the facility policy, Dressings, Dry/Clean dated 8/27/25, indicated in the Steps in the Procedure to cleanse hands between glove changes. Review of facility policy Enhanced Barrier Precautions dated 8/27/25, indicated the facility will implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDRO). Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include wound care (any surgical wound requiring a dressing, any pressure injury that is a Stage 2, 3, 4, unstageable or deep tissue injury requiring a dressing, and lacerations that require a dressing). Review of the clinical record revealed Resident R8 was readmitted to the facility on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 10/24/25, included diagnoses of peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of Section M: Skin Conditions indicated Resident R8 a stage four pressure ulcer (injury to the skin and underlying tissue, primarily caused by prolonged pressure on the skin, with full-thickness skin and tissue loss). Review of the plan of care for stage four pressure ulcer dated 10/23/25, indicated for staff to administer treatments as ordered and monitor for effectiveness. Review of the plan of care for enhanced barrier precautions dated 12/11/24, indicated gloves and gowns are worn for high contact care activity. Included in the list of high contact care was wound care. Review of a physician's order dated 7/6/25, indicated Resident R8 was ordered Enhanced Barrier Precautions related to the presence of a wound and a catheter. During an observation of a wound dressing change on 1/22/26, at approximately 11:00 a.m. the following was observed: -Licensed Practical Nurses (LPN) Employees E3 and E4 provided wound care without wearing gowns. -Resident R8 was noted to have a cloth underpad on his bed that was soiled with wound drainage. Per resident request, the ABD Pad (highly absorbent dressing that provides padding and protection for large wounds) covering the wound is left without a covering dressing. When the dressing change was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed, Resident R8 was rolled onto his back, onto the soiled underpad. -LPN Employee E4 did not clean her hands after removing the soiled gloves and putting on clean gloves. During an interview on 1/23/26, at approximately 1:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the failed to maintain infection control practices to prevent the potential for cross contamination while during wound care for one of six residents. Review of the facility policy Ice Machines and Ice Chests Maintenance dated 8/27/25, indicated that ice machines and ice storage/distribution containers will be used and maintained to assure a safe sanitary supply of ice. During an observation on 1/20/26, at 10:00 a.m., of the A/E and B/C pantries, each ice machine drainpipe was coiled into the drain with no space for an air gap, allowing for the potential for contamination of the ice in the ice machine. Used small heaters, paper towels gloves and wash basins were underneath the ice machines and debris such as gloves paper towels and dust were within and around the drain and ice machine drainpipe. During an interview on 1/20/26, at 10:15 a.m., Maintenance Director Employee E1 confirmed that the facility failed to maintain two of two ice machines in a sanitary manner. Review of the admission record indicated Resident R33 admitted to the facility on [DATE]. Review of Resident R33's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/14/26, indicated the diagnoses of heart failure (heart doesn't pump blood as well as it should), anxiety, and depression. Observation on 1/21/26, at 2:00 p.m. Resident R33 had a personal refrigerator in the room. The temperature log was dated October 2025. Review of the admission record indicated Resident R64 admitted to the facility on [DATE]. Review of Resident R64's MDS dated [DATE] indicated the diagnoses of atrial fibrillation (irregular heart rhythm), heart failure (heart doesn't pump blood as well as it should), and high blood pressure. Observation on 1/21/26, at 2:05 p.m. Resident R65 had a personal refrigerator in the room. The temperature log was dated October 2025. Interview on 1/21/26, at 2:10 p.m. the Nursing Home Administrator confirmed the facility failed to properly monitor residents in room personal refrigerator temperatures for two of two residents (Residents R33 and R64) which created the potential for food borne illness. Review of the facility policy Enhanced Barrier Precautions dated 8/27/25, indicated EBP employ targeted gown and glove use during high contact resident care activities. EBP are initiated for residents with wounds and MDRO (multiple drug-resistant organism). Review of the admission record indicated Resident R6 admitted to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R6's MDS dated [DATE] indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), heart failure (heart doesn't pump blood as well as it should), and high blood pressure. Review of Resident R6's physician order dated 12/7/25, indicated Enhanced Barrier Precautions related to history of MDRO/wound every shift. Observation on 1/21/26, at 10:00 a.m. Nurse Aide (NA) Employee E10 was providing morning care (personal hygiene, brief change, and dressing) to Resident R6. NA Employee E10 failed to have a gown during high contact resident care activities. Interview on 1/21/26, at 10:01 a.m. NA Employee E10 indicated the sign for EBP has been on Resident R6's door forever and staff did not have to wear a gown for resident's care. Interview on 1/21/26, at 1:00 p.m. the Infection Preventionist (IP) Employee E11 indicated Resident R6 was in EBP currently and did require a gown during high contact resident care activities. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 201.20(c) Staff development. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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	01/23/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on a review of facility policy, observations, and staff interviews, it was determined the facility failed to maintain a fully functioning resident call bell system that allows 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 in two of five rooms (Resident R10 and R46).Findings include: To ensure accessibility, the ADA (Americans with Disabilities Act) Standards for Accessible Design dated 9/15/10, indicated that emergency call system pull cords must be accessible to individuals with disabilities, ensuring they can reach the activation point from a seated or fallen position. While specific string length is not explicitly defined in inches by the ADA, the cord must be reachable, the operating mechanism must be within the ADA reach range of 15 to 48 inches from the floor Review of the facility policy Call System, Residents dated 8/27/25, indicated, Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. During an observation on 1/20/26, at 10:32 a.m. the call light in Resident R10's restroom was noted to be approximately three inches long, only the short portion of the chain extending from the wall, without a string or call pendant at the end of the string. During an observation on 1/20/26, at 10:35 a.m. the call light in Resident R46's restroom was noted to be approximately three inches long, only the short portion of the chain extending from the wall, without a string or call pendant at the end of the string. During an interview on 1/23/26, at 1:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to maintain a fully functioning resident call bell system that allows 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 in two of five rooms. 28 Pa Code 207.2(a) Administrators responsibility 28 Pa Code 205.28 (c)(1)(4) Nurses station