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	06/04/2026

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility review of policy, manufacturer's instructions, clinical records, and resident and staff interviews, the facility failed to notify physicians of elevated or decreased Capillary Blood Glucose (CBG) levels, failed to assess residents for hyperglycemia (high blood glucose) and hypoglycemia (low blood sugar), and failed to ensure the provision of insulin (injectable medication to treat high blood sugar) according to physicians' orders and manufacturing instructions which resulted in immediate jeopardy for eight of fourteen residents (R4, R6, R11, R19, R25, R32, R47, and R56).Review of the United States Food and Drug Administration prescribing information dated 03/2013, indicated that Humalog (insulin lispro) is a rapid acting insulin and directed to Administer within 15 minutes before a meal or immediately after a meal. Review of the United States Food and Drug Administration prescribing information dated 02/2015, indicated that Novolog (insulin aspart) and Should be generally given immediately (within 5-10 minutes) prior to the start of a meal. Findings include: Review of the facility provided document, Diabetes Management: Glucose Monitoring, Notification, and Documentation (undated) indicated: Timely Physician Notification ProceduresNotify the provider immediately for:Hypoglycemia (BG [blood glucose] < 70 with symptoms)Severe hyperglycemia (BG > provider-specific upper limit)Changes in mental status, level of consciousness, or refusal to eat. Documentation ExpectationsDocument the BG levels in designated flow sheets and EMR (electronic medical record).Record:Time and value of BG checkActions taken (e.g. insulin administered, glucose tabs given)Notification details: who was notified, time, and responseResident's response to interventionAny deviation from normal protocol and the reason Diabetes ProtocolsFollow facility-specific protocols for:Hypoglycemia: Give juice/glucose tabs, recheck in 15 minutes, documentHyperglycemia: Monitor for ketones, increase hydration, notify providerKeep protocols accessible on the unitEnsure timely re-assessments and follow-up documentation Review of the clinical record indicated that Resident R4 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs dated 5/14/26, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time)and hemiplegia (paralysis on one side of the body). Review of Resident R4's current plan of care for diabetes initiated 5/20/24, indicated Accuchecks as ordered, call MD per order/facility protocol. Review of a physician order dated 4/2/26, through 5/27/26, indicated that Resident R4 received Humalog insulin on a sliding scale. If 0 - 70 < 71, Notify MD; 401+ = 12 units > 400, Notify MD. Review of a physician's order dated 5/27/26, indicated, Check Blood Glucose before meals. Call Provider if greater than 300 or less than 70. Review of Resident R4's blood sugar record for May 2026, revealed the following blood sugar value failed to have documentation of notification or follow-up:5/06/26, 12:12 p.m. 56.0 mg/dL No notification. Orange juice given. No recheck.5/22/26, 12:01 p.m. 58.0 mg/dL No notification. Orange juice, glucose gel given. No recheck.5/24/26, 11:39 a.m. 64.0 mg/dL No notification. Orange juice given. No recheck.5/27/26, 12:23 p.m. 56.0 mg/dL No notification. No recheck. No documentation of protocol initiated.5/28/26, 11:39 a.m. 60.0 mg/dL No notification. No documentation of protocol initiated.5/30/26, 8:21 a.m. 320.0 mg/dL No recheck. No notification. Review of the clinical record indicated that Resident R11 was admitted to the facility on (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	[DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes and asthma (condition where the airways narrow and swell). Review of Resident R11's current plan of care for diabetes initiated 3/19/26, indicated Diabetes medication as ordered by doctor. Review of the plan of care dated 4/2/24, through 3/19/26, risk for hyperglycemia, indicated, Accu checks/BGMs/labs as ordered. Report to MD as ordered/per protocol. Medications as ordered. Review of a physician order dated 3/2/26, through 3/24/26, indicated that Resident R11 received 18 units of Humalog with meals, hold if less than 130 (mg/dl). Review of a physician order dated 3/24/26, through 4/1/26, indicated that Resident R11 received 16 units of Humalog with meals, hold if less than 130 (mg/dl). Review of a physician's order dated 4/2/26, through 4/3/26, indicated that Resident R11 received Humalog insulin on a sliding scale coverage with meals. Review of a physician's order dated 4/4/26, indicated that Resident R11 received Humalog insulin on a sliding scale coverage with meals (change in scale from previous order). Resident R11 had duplicated blood sugar levels from early morning insulin checks (between about 5:30 a.m. through 6:30 a.m.) documented at insulin provision times at breakfast (between about 8:00 a.m. through 8:30 a.m.). Documentation did not indicate a recheck was completed to ensure accuracy of the amount of insulin being given at breakfast. March: 3,4.5,6,7,9,10,11,12,13, 16,17,18,19,20,24,25,26,30,31April: 1,2,3,4,6,7,8,9,10,13,14,15,16,17,18,20,21,22,23,24,25,28,29,30May: 1,2,3,4,5,6,7,8,9,11,12,13,14,15,16,17,18,19,20,21,22,23,25,26,27,30,31 Review of Resident R11's Medication Administration Record indicated that the dosage of insulin was based upon the early morning blood glucose level. Further review of the MAR failed to reveal documentation of blood sugar level checks completed at breakfast time on 3/15/26, and 3/29/26. Review of the clinical record indicated that Resident R19 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes and a seizure disorder. Review of Resident R19's current plan of care for diabetes initiated 8/22/24, indicated Accuchecks (blood glucose checks) / labs as ordered. Report to MD per order/facility protocol. Review of a physician order dated 2/18/26, through 3/26/26, indicated that Resident R19 received 30 units of insulin aspart before meals. Notify MD if blood sugar is less than 70 greater than 450. This order was increased to 35 units on 3/26/26, to 40 units on 4/9/26, to 45 units on 4/20/26, to 50 units on 4/29/26, and to 55 units on 5/20/26. Review of a physician order dated 3/29/26, through 4/8/26, indicated that Resident R19 received Novolog on sliding scale coverage. <70, Notify MD >400 Notify MD. Review of a physician order dated 4/8/26, through 4/19/26, indicated that Resident R19 received insulin aspart on sliding scale coverage. Call MD if blood glucose less than 70 blood glucose greater than 400 call MD. Review of a physician order dated 4/20/26, through 4/26/26, indicated that Resident R19 received insulin aspart on sliding scale coverage. Call MD if blood glucose less than 70 blood glucose greater than 400 call MD. Review of a physician order dated 5/20/26, indicated that Resident R19 received insulin lispro on sliding scale coverage. Call PCP (primary care physician) if bg<70 call PCP if bg>401. Review of Resident R19's blood sugar record for March 2026, through May 2026, revealed the following blood sugar values failed to have documentation of notification or follow-up: 3/07/26 8:30 p.m. 463.0 mg/dL No recheck, no notification.3/21/26 5:32 p.m. 432.0 mg/dL No recheck, no notification.3/30/26 5:17 p.m. 425.0 mg/dL No recheck, no notification.4/09/26 4:32 p.m. 431.0 mg/dL No recheck, no notification.4/23/26 5:22 p.m. 429.0 mg/dL No recheck, no notification.4/25/26 9:06 a.m. 440.0 mg/dL No recheck, no notification.5/01/26 5:46 a.m. 414.0 mg/dL No recheck, no notification.5/01/26 8:42 a.m. 414.0 mg/dL No recheck, no notification.5/12/26 5:59 p.m. 424.0 mg/dL No recheck, no notification.5/19/26 6:25 a.m. 423.0 mg/dL No recheck, no notification.5/19/26 8:40 a.m. 423.0 mg/dL No recheck, no notification.5/21/26 6:45 a.m. 518.0 mg/dL Recheck done, no notification Resident R19 had duplicated blood sugar levels from early morning insulin checks (between about 5:30 a.m. through 6:30 a.m.) documented at insulin provision times at breakfast (between about 8:00 a.m. through 8:30 a.m.). Documentation did not indicate a recheck was completed to ensure accuracy of the amount of insulin being given at breakfast. March: 3,4.5,7,9,10,12,13,15,16,17,18,19,29,21,23,24,26,29,30,31April: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1,2,3,4,7,8,9,10,13,14,15,16,17,18,19,21,22,23,24,27,28,29,30May: 1,2,4,5,6,7,8,9,11,12,13,14,15,16,17,18,18,20,22,25,26,27,30,31 Review of Resident R19's Medication Administration Record indicated that the dosage of insulin was based upon the early morning blood glucose level. Further review of the MAR failed to reveal documentation of blood sugar level checks completed at breakfast time on 3/6/26, 3/27/26, 4/6/26, or 4/20/26. Review of the clinical record indicated that Resident R25 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes and heart failure (a progressive heart disease that affects pumping action of the heart muscles). Review of Resident R25's current plan of care for diabetes initiated 5/1823, indicated Administer med as ordered. Review of a physician order dated 3/26/26, indicated Inject 20 units subcutaneously one time a day for dm2 (diabetes mellites type two). Hold if blood glucose less than 150. Review of Resident R25's blood sugar record and insulin administration revealed the following: 3/28/26 141 mg/dL Insulin documented as given at 12:57 p.m. 4/04/26 149 mg/dL Insulin documented as given at 1:16 p.m.4/10/26 146 mg/dL Insulin documented as given at 12:09 p.m. 4/13/26 134 mg/dL Insulin documented as given at 11:44 a.m.5/05/26 127 mg/dL Ordered at 11:45 a.m., documented as given at 6:32 p.m.5/27/26 135 mg/dL Insulin documented as given at 12:27 p.m. Review of the clinical record indicated that Resident R32 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes and COPD. Review of Resident R32's current plan of care for diabetes initiated 8/23/26, indicated Administer med as ordered. Review of a physician order dated 2/19/26, through 3/26/26, indicated that Resident R32 received seven units of Humalog before meals. Hold if not eating or under 130. Review of a physician order dated 3/26/26, through 4/17/26, indicated that Resident R32 received ten units of Humalog before meals. Hold if not eating or under 130. Review of a physician order dated 4/17/26, indicated that Resident R32 received ten units of Humalog before meals. Hold if not eating or under 130. Review of Resident R32's blood sugar record and insulin administration revealed the following: 3/04/26 118 mg/dL Insulin documented as given at 5:42 a.m. 3/11/26 128 mg/dL Insulin documented as given at 5:35 a.m.3/16/26 128 mg/dL Insulin documented as given at 4:46 p.m.3/19/26 115 mg/dL Insulin documented as given at 5:15 p.m.4/06/26 128 mg/dL Insulin documented as given at 11:32 a.m.4/08/26 108 mg/dL Insulin documented as given at 5:34 a.m.4/13/26 113 mg/dL Insulin documented as given at 5:38 a.m.4/15/26 128 mg/dL Insulin documented as given at 5:30 a.m.4/18/26 123 mg/dL Insulin documented as given at 5:31 a.m.4/22/26 113 mg/dL Insulin documented as given at 5:30 a.m.4/23/26 118 mg/dL Insulin documented as given at 4:38 p.m.4/25/26 123 mg/dL Insulin documented as given at 5:43 a.m.4/28/26 108 mg/dL Insulin documented as given at 5:48 p.m.5/22/26 122 mg/dL Insulin documented as given at 6:23 a.m.6/01/26 128 mg/dL Insulin documented as given at 6:25 a.m. Review of the clinical record indicated that Resident R47 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes and heart failure. Review of Resident R19's current plan of care for diabetes initiated 2/3/26, indicated Diabetes medication as ordered by doctor. Review of a physician order dated 3/2/26, through 6/2/26, indicated that Resident R47 received Humalog on a sliding scale before meals and at bedtime. Timing for this order was 6:30 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. Review of Resident R47's insulin administration record indicated that the order for sliding scale coverage was provided usually between 5:30 a.m. and 6:30 a.m., approximately one to two hours before receiving breakfast. Review of the clinical record indicated that Resident R56 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes and chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness). Review of Resident R56's current plan of care for diabetes initiated 3/5/26, indicated Fasting Serum Blood Sugar/BGM/labs as ordered by doctor. Review of a physician order dated 2/18/26, through 4/16/26, indicated that Resident R56 received Novolog insulin on a sliding scale. 401+ = 10 Call MD. Review of Resident R56's blood sugar record for March 2026, through May 2026, revealed the following blood sugar value failed to have documentation (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	of notification or follow-up:3/30/26 5:48 a.m. 415.0 mg/dL No recheck, no notification.4/10/26 5:51 a.m. 470.0 mg/dL No recheck, no notification. During an interview on 6/1/26, at approximately 12:05 p.m. Resident R47 confirmed with the surveyor that the staff check the blood sugars daily between 5:30 a.m. and 6:00 a.m. and then the next shift nurse gives the insulin based on the prior shift blood sugar reading. Resident stated can't recall how often her blood sugar is rechecked in the morning before her insulin is given. During an interview on 6/1/26, at approximately 12:15 p.m. Resident R11 confirmed with the surveyor that the staff check the blood sugars daily between 5:30 a.m. and 6:00 a.m. and then the next shift nurse gives the insulin based on the prior shift blood sugar reading. Resident stated on occasion the nurse on the morning shift will recheck the blood sugar in the morning prior to giving the insulin. During an interview on 6/1/26, at approximately 12:30 p.m. Resident R19 confirmed with the surveyor that the staff check the blood sugars daily between 5:30 a.m. and 6:00 a.m. and then the next shift nurse gives the insulin based on the prior shift blood sugar reading. Resident stated that his blood sugar is rarely rechecked before his morning insulin is given. Staff Interviews completed on 6/1/26, between 12:00 p.m. through 1:00 p.m. revealed: Registered Nurse (RN) Employee E2 stated, The previous shift checks the blood sugars. I sometimes recheck the blood sugars. When asked if she did a recheck on Resident R19 this morning, RN Employee E2 stated, No used the blood sugar from the previous shift. Licensed Practical Nurse (LPN) Employee E3 stated, The previous shift is supposed to check blood sugars at 6:00 a.m. I often recheck and get my own blood sugars because they get them so early and I have a couple brittle diabetics. During observations completed on 6/2/26, the following meal tray delivery times were noted:E Hall (100s) passed trays at 7:33 a.m.B Hall (300s) passed trays at 7:40 a.m.A Hall (200s) passed trays at 7:46 a.m.C Hall (400s) passed trays at 7:58 a.m. Review of resident insulin administration times revealed:Resident R32 received 10 units rapid acting insulin at 5:54 a.m., 106 minutes prior to earliest possible tray receipt.Resident R6 received 8 units of rapid acting insulin at 5:54 a.m., 106 minutes prior to earliest possible tray receipt.Resident R25 received 16 units rapid acting insulin at 5:55 a.m., 123 minutes prior to earliest possible tray receipt.Resident R47 received 16 units rapid acting insulin at 5:55 a.m., 123 minutes prior to earliest possible tray receipt.Resident R56 received 8 units rapid acting insulin at 5:24 a.m., 142 minutes prior to earliest possible tray receipt. The Nursing Home Administrator (NHA) and the Director of Nursing (DON) were made aware that an Immediate Jeopardy situation existed for residents on 6/2/26, at 10:26 a.m. and a corrective action plan was requested. The Immediate Jeopardy template was provided to the facility administration at this time. The Immediate Jeopardy began March 3, 2026. On 6/2/26, at 4:00 p.m. an acceptable Corrective Action Plan was received which included the following interventions: The facility failed to ensure appropriate amounts of insulin to residents based on timely blood glucose checks. The facility failed to provide rapid-acting insulin (with a 15-30 time of onset) prior to meals. The facility failed to appropriately respond to resident blood sugar levels out of range, per the physician orders. This failure placed the residents at risk for complications related to hypoglycemia and/or hyperglycemia. Affected Residents / Immediate Actions:R19 was assessed by RN and evaluated for signs and symptoms of hypoglycemia/hyperglycemia glycemia and that RN assessed- notify dr of out of parameters; cp update as needed; provide meals at appropriate time. RN clarified blood sugar check order to ensure accuracy. R25 was assessed by RN and evaluated for signs and symptoms of hypoglycemia/hyperglycemia glycemia and that RN assessed- notify dr of out of parameters; cp update as needed; provide meals at appropriate time. RN clarified blood sugar check order to ensure accuracy. R56 was assessed by RN and evaluated for signs and symptoms of hypoglycemia/hyperglycemia glycemia and that RN assessed- notify dr of out of parameters; cp update as needed; provide meals at appropriate time. RN clarified blood sugar check order to ensure accuracy. R32 was assessed by RN and evaluated for signs and symptoms of hypoglycemia/hyperglycemia glycemia and that RN assessed- notify dr of out of parameters; cp update as needed; provide meals at appropriate time. RN clarified blood sugar check order to ensure (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	accuracy. R4 was assessed by RN and evaluated for signs and symptoms of hypoglycemia/hyperglycemia glycemia and that RN assessed- notify dr of out of parameters; cp update as needed; provide meals at appropriate time. RN clarified blood sugar check order to ensure accuracy. R11 was assessed by RN and evaluated for signs and symptoms of hypoglycemia/hyperglycemia glycemia and that RN assessed- notify dr of out of parameters; cp update as needed; provide meals at appropriate time. RN clarified blood sugar check order to ensure accuracy. Like Residents:The following items will be completed on 6/3/26 by 9:00 a.m.: DON/Designee will conduct house audit on all residents with orders to check blood glucose to ensure appropriate measures are taken and physician orders are followed, and order is appropriate. DON/Designee will conduct house audit on all residents with orders for insulin to ensure that physician orders are followed, meals are provided timely, and appropriate documentation occurs. Facility NHA and DON will review current nursing practice for blood glucose check during AM shift and will adjust time to ensure insulin and glucose checks are provided close to meal provisions. DON/Designee will conduct audit all current diabetic residents for potential change in condition, contact MD, update orders and care plan as needed. The DON/Designee will audit diabetic residents to ensure rapid-acting insulin is provided close to meal provision; and that blood glucose checks at the time of insulin provision. Correction of System: DON/Designee will educate licensed staff by 6/3/26 by 9:00 a.m. on Diabetic Protocol, the Hypoglycemia policy, and the Resident Change in Condition policy to include hyperglycemia is a change in condition and notification of the physician of blood sugars out of range. RNs and LPNs including upcoming agency that are not on duty received education via phone and will receive in person education on their next scheduled shift Monitoring: To monitor and maintain compliance, the Director of Nursing/ designee will review residents' blood sugars daily x seven days x four weeks, weekly x four weeks, monthly x two to ensure if any blood sugars were out of range and notifications made. If notification not documented, the physician will be contacted at the time of discovery and notified and new orders implemented as needed. To monitor and maintain compliance, new admissions/readmissions with diabetes will be reviewed by the DON/designee to ensure a care plan is implemented for diabetes including approaches for diabetic emergency management five times per week for two weeks. DON/Designee will conduct random meal delivery and insulin administration coordination audits during breakfast for two weeks to ensure safety of resident. Results of the audits will be forwarded to the center QAPI (Quality Assurance and Performance Improvement) committee for review and recommendations. On 6/3/26, the whole house audit of residents with diabetes was reviewed by surveyors, revealing its completion and accuracy. During interviews beginning at approximately 6:00 a.m. on 5/6/26, seven licensed nurses on overnight and morning shift were interviewed, and education was confirmed completed. Nursing staff were able to effectively describe appropriate actions to take when blood sugar levels are out of the accepted range for the residents, the need for documentation, the onset time of rapid-acting insulin, and the need to provide insulin based on a timely blood sugar measurement and with meals. On 6/3/26, licensed nursing reeducation was reviewed, revealing its completion. Review of the QAPI meeting document confirmed its completion on 6/2/26. The Immediate Jeopardy was removed on 6/3/26, at 11:15 a.m. when the action plan implementation was verified. During an interview on 6/4/26, at approximately 3:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to notify physicians of elevated or decreased Capillary Blood Glucose (CBG) levels, failed to assess residents for hyperglycemia and hypoglycemia, and failed to ensure the provision of insulin according to physicians' orders and manufacturing instructions which resulted in immediate jeopardy for eight of fourteen residents. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job descriptions, clinical records, and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility to provide care for residents with diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) consistent with standard nursing practices. This failure resulted in facility failures to notify physicians of elevated or decreased Capillary Blood Glucose (CBG) levels, failures to assess residents for hyperglycemia (high blood glucose) and hypoglycemia (low blood sugar), and failures to ensure the provision of insulin (injectable medication to treat high blood sugar) according to physicians' orders and manufacturing instructions which resulted in immediate jeopardy for eight of fourteen residents (R4, R5, R11, R19, R25, R32, R47, and R56).Findings include: Review of the facility-provided Nursing Home Administrator (NHA) job description indicated, Leads, guides and directs the operations of the healthcare facility in accordance with local, state and federal regulations, standards and established facility policies and procedures to provide appropriate care. Review of the facility-provided Director of Nursing (DON) job description indicated, Planning, organizing, developing and directing the overall operations of the Nursing Service Deportment in accordance with local, state and federal standards and regulations, established facility policies and procedures and as may be directed by the Administrator and the Medical Director, to provide appropriate care and services to the residents. Based on findings identified in this report, the facility failed to prevent the failed protect residents from exiting the facility unsupervised. The NHA and the previously employed DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 6/4/26, at approximately 3:00 p.m. the NHA and current DON confirmed that facility administration failed to effectively manage the facility to provide care for residents with diabetes consistent with standard nursing practices. This failure resulted in facility failures to notify physicians of elevated or decreased CBG levels, failures to assess residents for hyperglycemia and hypoglycemia, and failures to ensure the provision of insulin according to physicians' orders and manufacturing instructions which resulted in immediate jeopardy for eight of fourteen residents. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on a review of facility policy, federal regulation, and a staff interview, it was determined that the facility failed to provide transfer notices to representatives of the Office of the Long-Term Care Ombudsman Division for four of six months (December 2025 through March 2026).Findings include: Review of the facility policy Transfer or Discharge and Discharging the Resident dated 5/5/26 with a prior review date of 8/27/25, did not reveal evidence that the facility will provide notice to the Ombudsman and maintain documentation of the notice. Review of Title 42 Code of Federal Regulations S483.15(c)(3) Notice Before Transfer: indicates, before a facility transfers or discharges a resident, the facility must (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. Federal Regulations further define emergency transfers as, When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer. A request to review facility documents on 6/1/26, of the facility's compliance in notifying the State Ombudsman Office, revealed the facility failed to provide documented evidence of notifying the State Ombudsman Office of resident transfers and discharges for the time frame of 12/2025 through 4/2026. During an interview on 6/4/26, at 9:30 a.m., the Nursing Home Administrator confirmed the facility failed to provide transfer notices to representatives of the Office of the Long-Term Care Ombudsman Division for four of six months. 28 Pa. Code 201.18(b)(2) Management.

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	06/04/2026

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 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policy and resident and staff interviews, it was determined the facility failed to ensure that fresh drinking water was consistently readily accessible to residents to promote adequate hydration, meet resident preferences, and maintain their comfort for four of 20 residents reviewed (Residents 11, 19, 49, and 56).Findings include: Review of the facility policy Water Pitcher Pass/Cleaning dated 5/5/26 with a prior review date of 8/27/25, indicated the Nursing staff will fill water pitchers/Styrofoam cups with ice and fresh water placing them at bedside. Water will be provided/passed every shift unless contraindicated by their diagnosis or physician order. The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated that a BIMS (Brief Interview of Mental Status) is a brief screener that aids in detecting cognitive impairment. Scores from a BIMS assessment suggests the following distributions:13 - 15: cognitively intact8 - 12: moderately impaired0 - 7: severe impairment Review of the clinical record indicated Resident R49 was admitted to the facility on [DATE].Review of Resident R49's Minimum Data Set (MDS-a periodic assessment of care needs) dated 3/17/26, indicated diagnoses of coronary artery disease (CAD arteries become narrowed or blocked by buildup of plaque reducing blood flow to the heart), diabetes (body does not use insulin effectively), and depression (a serious, common mood disorder causing persistent sadness, low energy, and loss of interest in life for at least two weeks). Resident BIMS is 15. During an interview on 6/1/26, at approximately 1:30 p.m. with Resident R49 stated she has to ask during the day for water to drink. They always bring water to your room during the night shift you wake up and it's there, it's not often that they bring you water during the morning or afternoon shift. Review of the clinical record indicated Resident R19 was admitted to the facility on [DATE].Review of Resident R19's Minimum Data Set (MDS-a periodic assessment of care needs) dated 5/9/26, indicated diagnoses of seizure disorder (sudden disruptions of the brain's normal electrical activity), diabetes (body does not use insulin effectively), and hypertension (high blood pressure). Resident BIMS is 15. During an interview on 6/2/26, at approximately 10:30 a.m. with Resident R19 stated you have to ask at least fifty percent of the time, during the day for water to drink. They always bring water to your room during the night shift. Resident stated he keeps a lot of bottled water in his room that he has purchased, so he always has water available. Review of the clinical record indicated Resident R56 was admitted to the facility on [DATE].Review of Resident R56's Minimum Data Set (MDS-a periodic assessment of care needs) dated 3/17/26, indicated diagnoses of coronary artery disease (CAD arteries become narrowed or blocked by buildup of plaque reducing blood flow to the heart), diabetes (body does not use insulin effectively), and hypertension (high blood pressure). Resident BIMS is 15. During an interview on 6/2/26, at approximately 9:30 a.m. with Resident R56 stated occasionally during the day they give you water to drink. They bring water to your room during the night shift every night, you need to ask for it during the day on the days they don't bring you any and they will get it. Review of the clinical record indicated Resident R11 was admitted to the facility on [DATE].Review of Resident R11's Minimum Data Set (MDS-a periodic assessment of care needs) dated 3/17/26, indicated diagnoses of bilateral below the knee amputation (both legs amputated below the knee), diabetes (body does not use insulin effectively), and depression (a serious, common mood disorder causing persistent sadness, low energy, and loss of interest in life for at least two weeks). Resident BIMS is 15. During an interview on 6/3/26, at approximately 10:30 a.m. with Resident R11 stated during the day they bring you water to drink but not consistently. They bring water to your room during the night shift every night. During an interview with the Nursing Home Administrator (NHA) on 6/3/26, at 11:00 AM, confirmed the facility failed to ensure that fresh drinking (continued on next page)

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Wecare at South Hills Rehabilitation and Nrsg Ctr	201 Village Drive Canonsburg, PA 15317

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	water was consistently readily accessible to residents to promote adequate hydration, meet resident preferences, and maintain their comfort. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.28 Pa. Code 211.10(a)(c)(d) Resident care policies.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 policy, observations, and staff interview, it was determined that the facility to make certain that medical supplies were properly stored and/or disposed of in one of two medication rooms (B/C Medication Room).Findings include: Review of the United States Food and Drug Administration prescribing information dated November 2013, indicated, Vials in use for more than 30 days should be discarded. Review of the facility policy Storage of Medications dated 5/5/26, indicated medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. During an observation of the B/C Medication Room on 6/1/26, at 2:25 p.m. the following was observed: (2) open, partially used containers of protein powder with an expiration date of 3/18/26.(2) 1500 mL bottles of tube feeding formula with a use by date of 5/1/26.(1) Set of glucometer testing solution with an expiration date of 4/9/26.(1) Uncapped vial of Procrit injection solution.(1) Bottle of eye lubricating drops with a written expiration date of 5/30/26.(1) Opened, undated vial of tuberculin solution. During an interview on 6/1/26, at approximately 2:35 p.m. Licensed Practical Nurse Employee E4 confirmed the above observations. During an interview on 6/4/26, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to make certain that medical supplies were properly stored and/or disposed of in one of two medication rooms. 28 Pa. Code: 201.14 (a) Responsibility of licensee.28 Pa. Code: 201.18 (b)(1)(e)(1) Management.28 Pa. Code: 211.9 (a)(1) Pharmacy services.28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.