STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395434	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wecare at MT Lebanon Rehabilitation and Nrsg Ctr	350 Old Gilkeson Road Pittsburgh, PA 15228

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on review of select facility documents, clinical record review as well as resident and staff interviews, it was determined that the facility failed to ensure sufficient staffing to meet resident need for ten of 21 residents (Resident R4, R6, R7, R8, R13, R15, R18, R19, R30, R31).Findings include: Review of the facility, Staffing, Sufficient and Competent Nursing dated 1/22/25, indicated the facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. During an observation on 6/8/26, at 1:28 p.m. Resident R4's urinal was noted to be unemptied. Resident R4 had been served his noon meal a few minutes prior and the half-full urinal was on the overbed table next to Resident R4's meal. During an observation on 6/8/26, at 1:31 p.m. revealed Resident R6 to be unshaven with unkempt hair. During an observation on 6/8/26, at 1:32 p.m. revealed Resident R7 to be malodorous. During an observation on 6/8/26, at 1:34 p.m. revealed Resident R15 to be to be in a gown, in bed. Observation at this time showed what appeared to be feces smeared near Resident R15's pillow. The room had a strong odor of feces present. During a second observation at 5:50 p.m. revealed Resident R15 to still be in bed in the same gown. During an observation on 6/8/26, at 5:30 p.m. Resident R30 was noted to have tangled, unbrushed hair. During an interview on 6/8/26, at 5:19, when asked if the facility maintained sufficient staff to provide care for the residents, Resident R8 laughed and stated, No. When asked if call light response times were long, Resident R9 stated, Sometimes it takes a long time, sometimes they don't come at all. During an observation on 6/8/26, at 5:32 p.m. Resident R31 was noted to have greasy appearing hair. During an observation on 6/8/26, at 5:39 p.m. Resident R13 was noted to have greasy appearing hair and was wearing only a T-shirt and brief. During an observation on 6/8/26, at 5:46 p.m. a call light was heard to be alarming. Observation at this time revealed three staff members seated at the nurse's station. The call light alarmed for approximately three more minutes until a staff member noted the surveyor watching. At that point, the staff member answered the call light. During an interview on 6/8/26, at 5:52, when asked if the facility maintained sufficient staff to provide care for the residents, Resident R18 stated, No. They go through people like Grant went through Richmond. When asked if call light response times were long, Resident R18 stated, Yes, especially when you are in pain. Observation at this time revealed soiled linen left on Resident R18's floor. During an interview on 6/8/26, at 5:54, when asked if the facility maintained sufficient staff to provide care for the residents, Resident R19 stated, Could always use a few more bodies. Observation at this time revealed Resident R19 to have long facial hair. When asked, Resident R19 confirmed that he would like to be assisted to shave. During an interview on 6/8/26, at approximately 6:30 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure sufficient staffing to meet resident need for ten of 21 residents. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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

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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 interviews, it was determined that the facility failed to store medications properly, for one of two medication rooms (First-floor medication room).Findings include: Review of the facility policy Storage of Medications dated 1/22/25, indicated the facility stores all drugs and biologicals in a safe, secure, and orderly manner. During an observation of the First-floor medication room on 6/826, beginning at approximately 11:08 a.m., the following was observed:(1) vial of tuberculin solution was noted to be opened, and undated.(4) aerobic blood culture bottles with an expiration date of 4/2/26.(4) anaerobic blood culture bottles with an expiration date of 5/28/26.(2) I.V. start kits with an expiration date of 4/30/26.(4) collection tubes with an expiration date of 6/2/25.(94) collection tubes with an expiration date of 2/28/26.(24) urine collection tubes with an expiration date of 3/31/26. During an interview on 6/8/26, at approximately 11:20 a.m. Registered Nurse Employee E1 confirmed the above observations. During an interview on 6/8/26, at approximately 6:30 p.m. the Nursing Home Administrator confirmed that the facility failed to store medications properly for one of two medication rooms. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.9(a)(1)(2)(g)(h)(k) Pharmacy Services.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on a review of facility policies, documents, observations and resident and staff interviews it was determined that the facility failed to serve hot food products at acceptable palatable temperatures for two of two meals (lunch and dinner meal) and to ten of sixteen residents. (Residents R3, R8, R9, R10, R14, R16, R17, R21, R22, and R32).Findings include: The facility policy entitled Food Temperature Recording, dated 1/22/25, revealed all hot foods will be held and served at or above 135 ˆ (degrees Fahrenheit), and all cold foods will be held and served at or below 41 ˆ.Review of three months of Resident Council minutes (April-June 2026) revealed that on 5/7/26, the Resident Council voiced a concern related to cold food. Review of the Resident Council minutes from 6/4/26, indicated that the concern related to cold food remained unresolved.During an observation of the Main Kitchen noon meal tray line on 6/8/26, beginning at 12:35 p.m., it was noted:The facility utilized plastic plates. The plates were in the plate warming machine, but only slightly warm to the touch.Use of the facility provided thermometer revealed the plate temperature to be 90.3 ˆ.Observation of the tray assembly revealed that no bases were utilized for the plates, and a dome lid was placed over the plates on the tray.Observation of the food delivery carts confirmed that they do not have heating functionality.Observation of the tray placement on the delivery cart revealed that while the staff member who loaded the trays was unloading previously used trays, meals were left uncovered on the trays. During an observation on 6/8/26, beginning at 1:03 p.m. of the meal delivery on the First Floor unit, it was noted:The delivery cart doors were left open while two staff members delivered the trays to residents in their rooms.At 1:11 p.m. the last resident received their tray. During a resident tray assessment conducted on 6/8/26, at 1:12 p.m. it was revealed that the facility served the following food products with the following point of service temperatures that were taken by the surveyor while utilizing a facility owned thermometer, in the presence of nursing staff. Dietary staff were unavailable to witness temperature assessments.Pierogies 128.3 ˆCreamed corn 126.0 ˆDiced carrots 116 ˆ During resident interviews conducted during noon meal service on 6/8/26, the following was stated: -1:25 p.m. Resident R3 stated the food is often cold.-1:38 p.m. Resident R8 stated the food is frequently cold. During a resident tray assessment conducted on 6/8/26, at 5:45 p.m. it was revealed that the facility served the following food products with the following point of service temperatures that were taken by the surveyor while utilizing a facility owned thermometer, in the presence of nursing staff. Dietary staff were unavailable to witness temperature assessments.Macaroni and ground beef 113.6 ˆ During resident interviews conducted during evening meal service on 6/8/26, the following was stated: -5:19 p.m. Resident R9 stated, It's cold. It's all cold. Some of it's good, some of it's shit.-5:19 p.m. Resident R10 stated that sometimes the food is cold.-5:25 p.m. Resident R16 stated that sometimes the food is cold.-5:40 p.m. Resident R14 stated, Tell them to keep my dinner, it's cold.-5:50 p.m. Resident R17 stated the food is, pretty much always cold.-5:55 p.m. Resident R32 stated, Cold. The french fries are always cold and soggy.-5:58 p.m. Resident R21 stated the food is often cold.-6:00 p.m. Resident R22 stated the food is Sometimes not as warm as I'd like it to be, but I don't have a problem with that.During an interview on 6/8/26, at 6:30 p.m. the Nursing Home Administrator confirmed the above point of service temperatures and that facility failed to serve hot food products at acceptable palatable temperatures for two of two meals (lunch and dinner meal) and to ten of sixteen residents. 28 Pa Code: 211.6(b)(c) Dietary services

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on a review of resident choice menu selections, and Resident Group and staff interviews, it was determined that the facility failed to provide resident selected menu items for eight of 21 residents (R1, R2, R3, R5, R10, R11, R12, and R15).Findings include: During resident interviews conducted during noon meal service on 6/8/26, the following was stated: Resident R1 did not receive the ordered Glucerna (nutrition drink with a low sugar content) as indicated on the meal ticket.Resident R2 did not receive the milk, as indicated on the meal ticket.Resident R3 did not receive the ordered Glucerna as indicated on the meal ticket. Resident R3 stated, None today. Sometimes they substitute the milk shake, but that has too much sugar.Resident R5 did not receive double portions, as indicated on the meal ticket.Resident R15 did not receive the milk, as indicated on the meal ticket. Review of the meal tickets indicated that all residents had, 6 FL OZ (fluid ounces) hot beverage of choice. Observation during the meal delivery revealed a cart with a coffee carafe and sweeteners and creamers on it. Observation of fourteen residents' trays revealed all fourteen not to have a hot beverage present. During resident interviews conducted during evening meal service on 6/8/26, the following was stated:Resident R10 did not receive the canned fruit, as indicated on the meal ticket.Resident R11 did not receive the ice cream, as indicated on the meal ticket.Resident R12 did not receive the banana or receive double portions, as indicated on the meal ticket.During an interview on 6/8/26, at 6:30 p.m. the Nursing Home Administrator confirmed that the facility failed to provide ordered and selected food items to the residents. 28 Pa Code: 211.6(a) Dietary service.

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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 a review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to implement an effective system of surveillance designed to identify possible tuberculosis (TB a contagious bacterial infection that typically attacks the lungs) exposures for seven of twenty residents (R23, R24, R25, R26, R27, R28, and R29).Findings include: Review of the facility policy, Screening Residents for Tuberculosis dated 1/22/25, indicated the facility, Shall screen all residents for tuberculosis infection and disease (TB). During an interview on 6/8/26, at 2:52 p.m. the Director of Nursing confirmed that the facility's tuberculosis prevention program includes testing of all new admissions unless contraindicated. Review of the new admission orders indicated:-Tuberculin PPD (purified protein derivative or Mantoux test) Solution Inject 0.1 milliliter intradermally every day shift every 7 day(s) for monitoring for two administrations.-Read PPD 2 days after placement and record results in immunization tab every day shift every 7 day(s) for results for two administrations. Review of the clinical record indicated Resident R23 was admitted to the facility on [DATE]. Review of the April 2026 Medication Administration Record indicated that Resident R23 should have a TB skin test completed on 4/19/26, and 4/26/26, with the results to be read by nurses on 4/21/26, and 4/28/26. Review of the April 2026 MAR failed to reveal documentation that Resident R23 had tuberculosis skin tests completed on 4/19/26, and 4/26/26. Review of Resident R23's progress notes failed to reveal documentation of the reason for the omission. Review of the April 2026 MAR revealed that Resident R23's TB skin tests were read by nursing staff on 4/21/26, and 4/28/26. Review of the clinical record indicated Resident R24 was admitted to the facility on [DATE]. Review of the May 2026 MAR indicated that Resident R24 should have a TB skin test completed on 5/1/26, and 5/8/26, with the results to be read by nurses on 5/2/26, and 5/9/26. Review of the May 2026 MAR failed to reveal documentation that Resident R24 had a tuberculosis skin tests completed on 5/1/26. Review of Resident R24's progress notes failed to reveal documentation of the reason for the omission. Review of the May 2026 MAR revealed that Resident R24's TB skin tests were read by nursing staff on 5/2/26, and 5/9/26. Review of the clinical record indicated Resident R25 was admitted to the facility on [DATE]. Review of the May 2026 MAR indicated that Resident R25 should have a TB skin test completed on 5/12/26, and 5/19/26, with the results to be read by nurses on 5/14/26, and 5/21/26. Review of the May 2026 MAR failed to reveal documentation that Resident R25 had a tuberculosis skin test completed on 5/12/26. Review of Resident R25's progress notes failed to reveal documentation of the reason for the omission. Review of the May 2026 MAR revealed that Resident R25's TB skin tests were read by nursing staff on 5/14/26, and 5/21/26. Review of the clinical record indicated Resident R26 was admitted to the facility on [DATE]. Review of the May 2026 MAR indicated that Resident R26 should have a TB skin test completed on 5/14/26, and 5/21/26, with the results to be read by nurses on 5/16/26, and 5/23/26. Review of the May 2026 MAR failed to reveal documentation that Resident R26 had a tuberculosis skin test completed on 5/14/26. Review of Resident R26's progress notes failed to reveal documentation of the reason for the omission. Review of a progress note dated 5/16/26, at 11:22 a.m. indicated, resident does not recall getting a TB test, no documentation in chart under immunizations/progress note/MAR to indicate which arm TB test was given, unable to read. Review of the clinical record indicated Resident R27 was admitted to the facility on [DATE]. Review of the May 2026 MAR indicated that Resident R27 should have a TB skin test completed on 5/13/26, and 5/20/26, but the order was discontinued on 5/13/26 Review of the May 2026 MAR failed to reveal documentation that Resident R27 had a tuberculosis skin test completed on 5/13/26, or 5/20/26. Review of the May 2026 MAR revealed that Resident R27's TB skin tests were read by nursing staff on 5/15/26, and 5/22/26. Review of the clinical record indicated Resident R28 was admitted to the facility on [DATE]. Review of the June 2026 MAR indicated that Resident R28 should have a TB skin test completed on 6/3/26, and 6/10/26, with the results to be (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	read by nurses on 6/4/26, and 6/11/26. Review of the June 2026 MAR revealed documentation that Resident R28 had refused to have a tuberculosis skin test completed on 6/3/26, and 6/4/26. Review of the June 2026 MAR revealed that Resident R28's TB skin test was read by nursing staff on 6/11/26, and documented as negative Review of the clinical record indicated Resident R29 was admitted to the facility on [DATE]. Review of the June 2026 MAR indicated that Resident R29 should have a TB skin test completed on 6/6/26, and 6/13/26, with the results to be read by nurses on 6/8/26, and 6/15/26. Review of the June 2026 MAR revealed incorrect documentation for the TB test placed on 6/13/26, indicating the body location the test was placed at as 0.1. Review of the June 2026 MAR revealed that Resident R29's revealed blank documentation for the reading of the TB test on 6/15/26. During an interview on 6/8/26, at 6:30 p.m. the Nursing Home Administrator that the facility failed to implement an effective system of surveillance designed to identify possible tuberculosis exposures for seven of twenty residents. 28 PA. Code: 201.22(a) Prevention, Control, and Surveillance of Tuberculosis