STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395731	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Hills Post Acute	60 Highland Road Bethel Park, PA 15102

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview it was determined the facility failed to make certain a resident had an updated, person-centered care plan individualized to each specific resident's needs for four of six residents (Resident R90, R70, R21 and CR304).Findings include:Review of the facility policy Care Plan-Comprehensive Person-Centered dated 1/6/26, indicated each resident will have a comprehensive care plan developed that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs and will reflect current standards of practice for problem areas and concerns. Care plan interventions are chosen after data gathering, proper sequencing of events and careful consideration of the relationship between the resident's problem area and relevant clinical decision making.Review of Resident R90's clinical record indicated the resident was admitted to the facility on [DATE]. Resident discharged to the hospital on 5/9/26. The diagnoses identified in the clinical record indicated fractured ribs of right side after a fall, a stroke affecting his non- dominant side, a heart attack, heart dysrhythmia, heart failure and malnutrition.Review of Resident R90's clinical record identified a Brief Interview for Mental Status dated 4/30/26, indicating severe impairment. A Minimum Data Set (A periodic assessment of resident care needs) had not been completed as resident had not been in facility long enough.Review of Resident R90's care plan, dated 4/29/26, indicated resident has an impulsive behavior to get out of bed and was at risk for falls. Resident was to be reminded to call for help, call bell in reach and staff to anticipate his needs for assistance. No interventions for fall mats, monitoring, etc.Review of Resident R90's first fall indicated as being on 5/3/26, at 6:00 p.m., indicated Resident R90 had been incontinent and found on the floor by the Nurse Aide. Resident R90 was sent to the hospital when he could not respond to questions as the fall was not witnessed. And a head injury could not be ruled out.Review of Resident R90's plan of care dated 5/4/26, identified bed to be in low position, personal items within reach and resident to be in supervised view as much as possible.Review of Resident R90's second fall dated 5/9/26, at 1:00 a.m., indicated Resident R90 had fallen out of bed and had been incontinent and had a head laceration. The incident report did not indicate if bed was in low position, whether staff had toileted him prior, etc. (needs anticipated, as per plan of care).Review of Resident R70's clinical record indicated the resident was admitted to the facility on [DATE].Review of Resident R70's clinical record MDS dated [DATE], indicated diagnoses of heart arrythmia, falls, cognitive communication deficit, enlarging prostate and dizziness.Review of Resident R70's care plan, dated 3/28/26, last revised, indicated resident R70 was at risk for falls and the interventions identified staff to anticipate his needs, he was told to call for assistance, provide assistance for opening his door(the resident was stuck in his room when the door had been closed), no plan of care for toileting, monitoring, fall mats, etc.Review of the clinical record identified Resident R70 had a fall on 4/6/26, at 7:30 p.m., in the bathroom when he toileted himself and fell. Care plan to have toileting schedule.Review of the clinical record indicated Resident R70 fell out of bed on 4/7/26, at 3:45 p.m., when he attempted to get out of bed to wheelchair to go to bathroom and was incontinent. When had he been toileted? Review of the clinical record indicated Resident R70 had a fall on 4/26/26, at 4:15 (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m., when he attempted to get into bed for a nap and lost balance. No care plan changes.Review of the clinical record indicated Resident R70 had a fall at 10:45 a.m., in the bathroom attempting to toilet self. Educated on asking for help.Review of Resident R21's clinical record indicated the resident was admitted to the facility on [DATE].Review of Resident R21's clinical record MDS dated [DATE], indicated diagnoses of heart arrythmia with pacemaker, muscle disorder, insomnia, anxiety and blood clots to lungs.Review of Resident R21's care plan, dated 2/13/26, indicated resident R21 was at risk for falls and the interventions identified staff to anticipate his needs, he was told to call for assistance, and leave items within reach. No plan of care for toileting, monitoring, fall mats, etc.Review of the clinical record indicated Resident R21 had fallen on 4/7/26, at midnight out of her recliner attempting to reach for her lotion to put on her legs. Why were items not in her reach as per plan of care. Care plan indicated resident to call for assistance.Review of the clinical record indicated Resident R21 had fallen on 4/10/26, in the bathroom when toileting self. No care plan changes.Review of Resident CR304's clinical record indicated the resident was admitted to the facility on [DATE]. Resident had been discharged .Review of Resident CR304's clinical record MDS dated [DATE], indicated diagnoses of heart arrythmia, falls, kidney disease and spinal stenosis and obesity.Review of Resident CR304's care plan, dated 4/2/26, indicated resident R304 was at risk for ADL decline and required assistance of one staff for bed mobility and transfers. Interventions included residents asking for help.Review of the clinical record indicated Resident CR304 had slid out of bed onto the floor on 4/12/26, at 5:00 a.m., with no changes in plan of care, mattress, etc.Review of the clinical record indicated Resident CR304 had a witnessed fall when the resident was standing at bedside alone holding onto her wheelchair and lost balance and lowered herself to the floor. Resident CR304 was attempting to get herself to the toilet. She was identified as an assistance of one, the Nurse Aide witnessed it but had not been assisting her.During an interview on 5/13/26, at approximately 10:32 a.m., with Director of Nursing (DON) and Nursing Home Administrator (NHA), the DON reviewed the care plans and stated that they had been updated. Further explanation indicated that the plans had not been followed and were not resident specifically driven with measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs and will reflect current standards of practice for problem areas and concerns. The facility failed to make certain that residents had an updated, person-centered care plan individualized to each specific resident's needs four of six residents (Resident R90, R70, R21and CR304). 28 Pa. Code 211.11(a)(b)(c)(d) Resident care plan. 28 Pa. Code 211.12(d)(1)(3)(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 facility policy, clinical record 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 four residents (Resident R90).Findings include:Review of the facility policy Accidents and Incidents- Investigating and Reporting dated 1/6/26, indicated that all accidents and incidents involving residents, employees, etc., occurring on the premises shall be investigated and reported to the Administrator. The Nurse Supervisor shall promptly initiate and document the investigation of the accident or incident. Incident/Accident reports will be reviewed by the Safety Committee for trends related to the accident and analyze any individual resident vulnerabilities.Review of Resident R90's clinical record indicated the resident was admitted to the facility on [DATE]. Resident discharged to the hospital on 5/9/26. The diagnoses identified in the clinical record indicated fractured ribs of right side after a fall, a stroke affecting his non- dominant side, a heart attack, heart dysrhythmia, heart failure and malnutrition.Review of Resident R90's clinical record identified a Brief Interview for Mental Status dated 4/30/26, indicating severe impairment. A Minimum Data Set (A periodic assessment of resident care needs) had not been completed as resident had not been in facility long enough.Review of Resident R90's admission fall risk assessment dated [DATE], indicated that Resident R90 was a moderate risk. Review of Resident R90's Documentation Survey Report V2(report that is produced from the Nurse Aide documented actual care provided and used when completing Section GG on the MDS) dated [DATE], identified Resident R8 as 02 Substantial/ Maximum assistance for transfers including toileting.Review of Resident R90's care plan, dated 4/29/26, indicated resident has an impulsive behavior to get out of bed and was at risk for falls. Resident was to be reminded to call for help, call bell in reach and staff to anticipate his needs for assistance. No interventions for fall mats, monitoring, etc.Review of Resident R90's first fall indicated as being on 5/3/26, at 6:00 p.m., indicated Resident R90 had been incontinent and found on the floor by the Nurse Aide. Resident R90 was sent to the hospital when he could not respond to questions as the fall was not witnessed. And a head injury could not be ruled out.Review of Resident R90's plan of care dated 5/4/26, identified bed to be in low position, personal items within reach and resident to be in supervised view as much as possible.Review of Resident R90's second fall dated 5/9/26, at 1:00 a.m., indicated Resident R90 had fallen out of bed and had been incontinent. The incident report did not indicate if bed was in low position, whether staff had toileted him prior, etc. (needs anticipated, as per plan of care).During an interview on 5/13/26, at approximately 10:32 a.m., the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to make certain each resident received adequate supervision and assistance to prevent accidents for one of four residents (Resident R90). 28 Pa. Code 201.18(e)(1) Management.28 Pa. Code 201.29(a)(c)(d) Resident rights.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility documents, and staff interviews, it was determined that the facility failed to provide a Notice of Medicare Non-Coverage (NOMNC) for two of three residents (Residents R302, and R303).Findings include:Review of form instructions for the Notice of Medicare Non-Coverage (NOMNC) indicated a Medicare health provider must give an advanced copy of the NOMNC to enrollees receiving skilled nursing, home health, or a comprehensive outpatient rehabilitation facility no later than two days before termination of services.A review of the facility NOMNC form indicated that the resident has a right to appeal non-payment of services, your request must be made no later than noon of the day before the effective date of non-coverage. Review of the clinical record indicated Resident R302 was admitted to the facility on [DATE], and the last covered day of Part A service was 1/23/26. Review of a progress note dated 1/23/26, at 12:53 p.m. revealed Discharge Note: Patient is electing to discharge to home today 1/23/26 via family. Further review of the clinical record failed to reveal a NOMNC was given and signed by Resident R302 indicating they understood the appeal process. Review of the clinical record indicated Resident R303 was admitted to the facility on [DATE], and the last covered day of Part A service was 4/8/26.Review of a progress note dated 4/3/26, at 1:21 p.m. revealed Discharge Note: patient is electing to discharge to home on 4/7/26, at 4:00 p.m. via family. Review of a progress note dated 4/6/26, at 10:52 a.m. revealed Patient is now electing to discharge to home on 4/8/26.Review of a physician order dated 4/6/26, indicated discharge to home on 4/8/26, with home health.During an interview on 5/14/26, at 10:00 a.m. the NHA confirmed that the facility was unable to provide the NOMNC forms for Residents R302 and R303.28 Pa. Code 201.29(a): Resident rights.