STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395948	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center at Jefferson Hills, The	540 Coal Valley Road Jefferson Hills, PA 15025

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on resident and staff interviews, it was determined that the facility failed to provide reasonable access to mail services as available in the community to all residents of the facility.Findings include: A review of the facility policy Mail last reviewed 12/5/25, indicated Delivery of mail or other materials to the resident within 24 hours of delivery by the postal service (or facility post office box) and delivery of outgoing mail to the postal service within 24 hours, when there is no regularly scheduled postal delivery and pick-up service. During a group interview on 2/11/26, at approximately 11:30 a.m., consensus from the group revealed that residents reported the facility did not deliver mail or provide mail services on Saturdays. Review of the facility documents (activity calendars) for the past six months from 9/25 through 2/26 reveal a statement of Mail Delivery is Monday - Friday During an interview on 2/12/26, at 1:15 p.m. Activities Director Employee E1 confirmed that she does not deliver mail on Saturday as she is not in the building on weekends and she is the only employee of the activity department. During an interview on 2/13/26, at 9:22 a.m. Business Office Manager Employee E4 stated the facility does not get mail delivered on Saturday from the postal service. During an interview on 2/13/26, at 9:45 a.m. the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to ensure mail was delivered to the residents on Saturdays. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(2) Management 28 Pa. Code 201.29(j) Resident rights

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: 395948	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2026

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F 0579 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide information about how to apply for and use Medicare and Medicaid benefits. Based on observations and a staff interview, it was determined that the facility failed to display (for residents and/or their responsible person) written information on how to apply for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid as required, in the building, where postings are available (first floor lobby). Findings include: The facility must display in the facility, written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. During observations completed on 2/11/26, at approximately 11:30 a.m., in the lobby, hallways in and around the nursing units, revealed the facility failed to include information on how to apply for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid. During rounds and an interview with the Nursing Home Administrator (NHA) on 2/12/26, at 9:00 a.m., the NHA confirmed the facility failed to display (for residents and/or their responsible person) written information on applying for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid as required, in the building. 28 Pa. Code: 201.14(a)Responsibility of licensee. 28 Pa. Code: 201.18(e) Management.

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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 observations, resident, and staff interviews, it was determined that the facility failed to provide a safe, clean, comfortable, and homelike environment on one of two nursing units (North Nursing Unit).Findings include: Review of the facility policy Resident Environment dated 12/5/25, indicated in part The facility will provide an environment that is safe, clean comfortable and homelike, allowing the resident to use his or her personal belongings to the extent possible. During an observation on 02/12/2026, at 8:30 a.m., the following was identified: Residents R19 and R30 had tape surrounding the ceiling air vent. The air vent and tape had dust collected on both. Residents R4 and R41 had the rubber baseboard molding pulled away from the wall, for the entire length of the wall. Residents R26 and R40 had the rubber baseboard molding pulled away from the wall, for the entire length of the wall. Resident R26 had approximately a 30.61-millimeter hole in the wall at the outlet junction box that was in use. This was located near the floor between the head of Resident 26 bed and the outside wall. Hallway outside (room [ROOM NUMBER]) the ceiling has a cracked and partially patched and unpainted area. North Hallway handrails appear to have unpainted patched spots on both sides of the hall. Physical Therapy Department has a large vent in the middle of the room that has dust weaved throughout the vent. During an interview with Resident R26 and his parents, they confirmed that the room condition have been in existence since admission. During rounds and an interview on 2/12/26, at 9:00 a.m., the Nursing Home Administrator confirmed the above findings and that the facility failed to provide a safe, clean, comfortable, and homelike environment. 28 Pa. Code: 207.2(a) Administrator's responsibility.28 Pa. Code: 201.29(k) Resident rights.

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NAME OF PROVIDER OR SUPPLIER: Rehabilitation Center at Jefferson Hills, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 540 Coal Valley Road, Jefferson Hills, PA 15025	

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on review of facility policy, observations, and resident and staff interviews, it was determined that the facility failed to make accessible grievance boxes to residents in three of three locations where grievances boxes are located (main lobby, north and south nursing units). Findings include: A review of the facility policy Grievances/Complaints, Filing reviewed 1/16/25, grievances and/or complaints may be submitted orally or in writing and may be filed anonymously. The Centers for Medicare & Medicaid Services (CMS) does not specify exact height requirements for grievance boxes in skilled nursing facilities. However, CMS mandates that grievance procedures be accessible to all residents, including those with disabilities, in compliance with the Americans with Disabilities Act (ADA). In Pennsylvania, the Department of Health incorporates by reference the federal requirements outlined in 42 CFR Part 483, Subpart B, which pertains to long-term care facilities. These regulations emphasize the importance of accessibility but do not provide additional specifications regarding grievance box placement. To ensure accessibility, the ADA Standards for Accessible Design recommend that operable parts, such as slots on grievance boxes, be mounted between 15 and 48 inches above the floor. This range accommodates individuals using wheelchairs and ensures usability for a broad range of residents. During a resident group interview, on 2/11/26 at approximately 11:30 a.m., when asked if they felt they could anonymously file a grievance in the grievance boxes, consensus from the group was no. Residents stated, there a couple of boxes they are too high to reach, they are not made for people in wheelchairs, the boxes are in view of the staff, and you have to ask someone to help you, so we just ask the staff to do it for us. During an observation and interview on 2/12/26, at 9:00 a.m. the Nursing Home Administrator and surveyor measured the height of the grievance boxes; the lobby height was 54 inches, north nursing unit box height was 53 inches, and south nursing unit box, height was 57 inches. The box in the lobby was in view of the reception desk and blocked by a chair, the north nursing unit box was in view of the nursing station, and the south nursing unit box was blocked by a cart with a cooler in front of it and the box is in view of the nursing station. During an interview on 2/12/26, at 9:00 a.m. the Nursing Home Administrator confirmed the facility failed to make accessible grievance boxes to residents. 28 PA Code: 201.18(e)(4) Management.28 PA Code: 201.29(a)(b)(c) Resident rights.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on a review of scheduled activities, observations, and staff interviews, it was determined that the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of residents. Findings include: Review of the activity's calendars for the facility, from September through February 2026 revealed there are no group activities on Sunday's. There are three activities a day listed on the calendar with the last activity at 1 pm following lunch in the dining room. Review of the Activities calendar from September 2025 through February 2026 revealed the following: Daily9:30 a.m. 1 on 1 visits by distributing the facility Daily Chronicle (document for residents to read).11:30 a.m. Lunch Monday through Friday1:00 p.m. group activity Saturday1:00 p.m. rotating cycle one Saturday puzzles, one Saturday coloring, and one Saturday games. Sunday1:00 p.m. residents' choice a cart with books, magazines and items is taken around the facility if residents want to select something to do independently. During a group interview on 2/11/26, at approximately 11:30 a.m., consensus from the group revealed that residents would like additional activities. Residents stated there is only one activity during the week, it's at 1 pm. Residents stated they want to do something, not just have a cart that they can pick up something to do in their room on their own. The residents verbalized that they like the socialization of the group activity. The residents stated there isn't much to do on the weekend. During an interview on 2/11/26, at 1:15 p.m. Activities Director Employee E1 stated there is no activity coverage on the weekend from the activity department at this time. The activity assistant left the department approximately six months ago. Employee E1 confirmed that there is only one group activity during the week at 1:00 p.m. and she is not in the building to confirm the weekend activities. During an interview on 2/13/26, at approximately 9:30 a.m. the Nursing Home Administrator confirmed the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of residents on one of five nursing units. 28 Pa. Code: 201. 18(b)(3) Management.28 Pa. Code: 207.2(a) Administrators Responsibility.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on review of facility policy, personnel records, and staff interview, it was determined that the facility failed to ensure that the Activities Department had a qualified director to oversee the activities program.Findings include: The facility Activities Director employee job description indicated; The primary purpose of the job position is to plan, organize, implement, evaluate and direct the Activity Programs in accordance with the current federal, state, and local standards governing the facility and as directed by administrator, to ensure that the emotional, recreational, and social needs of the residents are met and maintained on an individual basis. Review of Activities Director Employee E1's personnel record indicated she was hired on 1/9/25. Review of Activities Director Employee E1's personnel record did not include evidence that Activities Director Employee E1 had proper qualifications as an Activities Director. The personnel record did not include previous history as an Activity Director, education in therapeutic services, education as a social worker or occupational therapist, or a background in recreational services. During an interview on 2/12/26, at 1:15 p.m. Activities Director Employee E1 confirmed that she did not have education in therapeutic services, education as a social worker or occupational therapist, or a background in recreational services. During an interview on 2/12/26, at 1:25 p.m. Occupational Therapist Employee E3 confirmed that she did not have any oversite or involvement with the activity program at the facility. Employee E3 confirmed that she was the only regularly scheduled Occupational Therapist for the facility. During an interview on 2/12/26, at 1:35 p.m. Certified Occupational Therapy (COTA) Rehabilitation Services Director, Employee E2 confirmed that she only completes the mobility portion of the activities assessment in the clinical record and did not have any other involvement or oversite with the facility activity department programing or employee. During an interview on 2/13/26, at 9:45 a.m. the Nursing Home Administrator confirmed that the facility failed to ensure that the Activities Department had a qualified director to oversee the activities program.28 Pa Code 201.18(b)(3) Management28 Pa Code 201.189(e)(6) Management

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, observations, and staff interviews, it was determined that the facility failed to provide prescribed treatments and services related to the care of pressure ulcers and/or pressure ulcer prevention for three of six residents (Resident R6, R7, and R23).Findings Include: Review of the United States Department of Health and Human Services, Agency for Healthcare Research & Quality's, Safety Program for Nursing Home: On-Time Pressure Ulcer Prevention dated May 2016, indicated that Pressure ulcers cause pain, disfigurement, and increased infection risk and are associated with longer hospital stays and increased morbidity and mortality. Three critical components in preventing pressure ulcers were listed: comprehensive skin assessments, standardized pressure ulcer risk assessments, and care planning and implementation to address areas of risk. Review of the National Library of Medicine, The Braden Scale for Predicting Pressure Sore Risk indicated the scale was developed to foster early identification of patients at risk for forming pressure ulcers. Review of the facility policy, Pressure Ulcers dated 12/5/25, indicated, Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time. Residents will receive skin care, repositioning, and nutritional support to assist in preventing the development of avoidable pressure ulcers. The scale consists of six subscales and the total range from 6-23, with the following distributions:-Severe Risk: Less than or equal to 9.-High Risk: 10-12.-Moderate Risk: 13-14.-Mild Risk: 15-18. Review of the clinical record indicated that Resident R6 was admitted to the facility on [DATE]. Review of the Minimum Data Sent (MDS - periodic assessment of resident care needs) dated 2/2/26, included hemiplegia (paralysis on one side of the body), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and high blood pressure. Section M: Skin Conditions indicated Resident R6 has a Stage III pressure ulcer. Review of the most recent Braden Scale for Predicting Pressure Sore Risk (tool help health professionals assess a patient's risk of developing a pressure ulcer) completed on 9/9/21, indicated Resident R6 was at risk for pressure ulcer development. Review of R6's plan of care for risk of skin integrity impairment revised on 2/11/26, indicated to offload both heels while in bed every shift, turn and reposition Q2 (every two) hours, and wear palm guard on left hand at all times except during hygiene tasks. Review of a physician order dated 9/14/22, indicated a turn and position q2 (every two) hours while in bed. Review of a physician's order 8/21/23, indicated, Please use off-loading cushion under left calf to keep pressure off of left heal. Review of a physician's order 8/23/24, indicated, off load both heels while in bed. Review of Resident R6's treatment administration record (TAR) for February 2026, revealed Resident R6's palm guard was applied on 2/11/26, and 2/12/26. During an observation on 2/11/26, at 11:30 a.m. and Resident R6 was observed lying on his back, heels not offloaded, without the palm guard in place. During observations on 2/12/26, at 9:15 a.m., 11:00 a.m., 12:52 p.m., and 2:45 p.m. Resident R6 was observed lying on his back, heels not offloaded, without the palm guard in place. During observations on 2/13/26, at 8:45 a.m. and 10:45 a.m. Resident R6 was observed lying on his back, heels not offloaded, without the palm guard in place. During an interview on 2/13/26, at approximately 10:45 a.m. when asked if staff assisted him to elevate his heels or apply his palm guard, Resident R6 stated, Sometimes. During an interview on 2/13/26, at approximately 11:00 a.m. Licensed Practical Nurse (LPN) Employee E17 confirmed that Resident R6's heels were not offloaded, and he did not have a palm guard in place. Review of the clinical record indicated that Resident R7 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking), diabetes, and muscle weakness. Section M: Skin Conditions indicated Resident R7 has a (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Stage IV pressure ulcer. Section GG: Functional Ability indicated that Resident R7 required assistance to roll left and right in bed. Review of the most recent Braden Scale for Predicting Pressure Sore Risk completed on 3/14/23, indicated Resident R7 was at high risk for pressure ulcer development. Review of R7's plan of care for risk of skin integrity impairment revised on 2/11/26, indicated heel pillow boots to be on when in bed, turn and reposition Q2 hours, and to use wedge cushion to offload buttocks off sides. Review of a physician order dated 3/28/23, indicated, Use wedge cushion to offload buttocks off sides Q4 (every four) hours. Review of a physician order dated 5/25/23, indicated a turn and position q2 hours while in bed. During observations on 2/12/26, at 9:15 a.m., 11:00 a.m., 12:52 p.m., and 2:45 p.m. Resident R7 was observed lying on her back, without a wedge in place. The wedge was observed in the chair next to the bed. During observations on 2/13/26, at 8:45 a.m. and 10:45 a.m. Resident was observed lying on her back, without a wedge in place. The wedge was observed in the chair next to the bed. During an interview on 2/13/26, at approximately 8:45 a.m. when asked if staff assist in positioning her wedge, Resident R7 shook her head negatively. Review of the clinical record indicated that Resident R23 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included hemiplegia, aphasia (language disorder that affects communication and difficulty speaking), and history of a stroke. Section M: Skin Conditions indicated Resident R23 was at risk for pressure ulcer development. Section GG: Functional Ability indicated that Resident R23 required assistance to roll left and right in bed. Review of the most recent Braden Scale for Predicting Pressure Sore Risk completed on 7/30/21, indicated Resident R23 was at moderate risk for pressure ulcer development. Review of R23's plan of care for risk of skin integrity impairment revised on 4/21/25, indicated to obtain wedge for offloading in bed and to turn and reposition Q2 hours. Review of a physician order dated 4/27/22, indicated, Turn and position q2 hours. Review of a physician order dated 1/17/25, indicated, Obtain wedge for offloading while in bed. During an observation on 2/11/26, at 11:30 a.m. and Resident R6 was observed without a wedge in place. During observations on 2/12/26, at 9:15 a.m., 11:00 a.m., 12:52 p.m., and 2:45 p.m. Resident R6 was observed without a wedge in place. During observations on 2/13/26, at 8:45 a.m. and 10:45 a.m. Resident R6 was observed without a wedge in place. During an interview on 2/13/26, at approximately 11:00 a.m. LPN Employee E17 confirmed that Resident R23 did not have a positioning wedge. During an interview on 2/13/26, at approximately 12:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide prescribed treatments and services related to the care of pressure ulcers and/or pressure ulcer prevention for three of six residents. 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)(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. Based on observations and staff interview it was determined that the facility failed to provide a safe environment for residents in one of two nursing units (waste room and staff restroom). Findings include:During an observation on 2/11/26, at approximately 11:45 a.m. the biohazardous waste room was noted to be unlocked. Within the room were 13 sharps containers on a shelf and two large biohazardous waste bag with multiple sharps containers in them on the floor. During an observation on 2/11/26, at approximately 11:50 a.m. the beauty shop was noted to be unlocked. Within the room was an environmental services cart with cleaning supplies and a large putty knife on top. During an observation on 2/11/26, at approximately 11:53 a.m. the staff restroom was noted to be not fully closed. Observation of the restroom revealed no emergency call light or call cord attached for emergency use. During an observation on 2/12/26, at approximately 11:00 a.m. the biohazardous waste room and the staff restroom were noted to be unlocked and accessible to residents. During an observation on 2/13/26, at approximately 10:45 a.m. the biohazardous waste room and the staff restroom were noted to be unlocked and accessible to residents. During an interview on 2/13/26, at approximately 10:50 a.m. Licensed Practical Nurse Employee E17 confirmed the biohazardous waste room was unlocked, and at that time she engaged the locking mechanism on the interior side of the door. At approximately 10:52 a.m. LPN Employee E17 confirmed that the staff restroom was unlocked and accessible to residents and that a call light was not available for use. During an interview on 2/13/26, at approximately 12:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide a safe environment for residents in one of two nursing units. 28 Pa. Code 201.18(e)(1) Management.28 Pa. Code 201.20(a)(b) Staff development.28 Pa. Code 201.29(a)(c)(d) Resident rights.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 failed to make certain that medications were properly stored and/or disposed of in one of two medication carts and one of two medication storage rooms (North Hall storage room and South Hall medication cart).Findings include:Review of facility policy Storage of Medications dated 12/5/25, stated that medications are stored in a safe, secure, and orderly manner in accordance with federal and state regulations and facility policies. During an observation of the North Unit medication room on 2/11/26, at approximately 12:00 p.m. the following was observed:59 blood collection tubes with an expiration date of 10/31/25.7 blood collection tubes with an expiration date of 1/31/25.2 vacutainers with an expiration date of 11/30/25.3 vacutainers with an expiration date of 10/31/25.8 IV start kits with an expiration date of 11/30/23.4 IV extension sets with an expiration date of 5/31/25.1 syringe with an expiration date of 9/30/24.3 syringes with an expiration date of 6/1/25.4 package antibiotic ointment with an expiration date of 05/2025.1 box of (100) cleansing towelettes with an expiration date of 6/28/25.27 oral fluid collection devices with an expiration date of 03/2025.1 vial of tuberculin solution in the medication room refrigerator, partially used and undated. During an interview on 2/11/26, at 12:15 p.m. Licensed Practical Nurse Employee E10 confirmed the above observations. During an observation of the South Unit medication cart on 2/12/26, at approximately 8:35 a.m. the following was observed:-(1) bottle of Timolol eye drops, open and undated on bottle and storage container.-(1) bottle of Dorzolamide/Timolol open and undated on bottle and storage container.-(1) bottle of Latanoprost open and undated on bottle and storage container.Employee E16 confirmed that the above observation of medications not being labeled with dates on bottles or storage containers were noted on the multi-dose bottles that were in her cart when she started medication administration.During an interview on 2/12/26, at approximately 9:15 a.m. the Director of Nursing confirmed that the facility failed to make certain that unlabeled medications were in one of two medication carts and out of date supplies were properly stored and/or disposed of in one of two medication storage 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.

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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 0941 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on resident rights for nine of thirteen staff members (Employee E5, E6, E7, E8, E9, E10, E11, E12, E13, E14, and E15).Findings include: Review of the facility policy, Staff Development Program most recently reviewed 12/5/25, indicated, There shall be an ongoing coordinated education program which is planned and conducted for the development and improvement of skills of the facility personnel, including training related to technology, problems, needs and rights of residents Review of facility provided documents and training records revealed the following staff members did not have documented training on the resident rights Program. Nurse Aide Employee E5 had a hire date of 10/24/25, and failed to have resident rights education upon hire or thereafter.Nurse Aide Employee E6 had a hire date of 11/23/25, and failed to have resident rights education upon hire or thereafter.Nurse Aide Employee E7 had a hire date of 2/5/24, failed to have resident rights in-service education between 2/5/25, and 2/5/26.Nurse Aide Employee E8Licensed Practical Nurse Employee E9 had a hire date of 11/24/25, and failed to have resident rights education upon hire or thereafter.Licensed Practical Nurse Employee E10 had a hire date of 1/29/24, failed to have resident rights in-service education between 1/29/25, and 1/29/26.Registered Nurse Employee E11 had a hire date of 1/14/16, failed to have resident rights in-service education between 1/14/25, and 1/14/26.Therapy Employee Employee E12 had a hire date of 12/12/22, failed to have resident rights in-service education between 12/12/25, and 12/12/26.Therapy Employee Employee E13 had a hire date of 12/18/23, failed to have resident rights in-service education between 12/18/25, and 12/18/26. During an interview on 2/13/26, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on resident rights for nine of thirteen staff members 28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.18 (b)(1) Management.28 Pa Code: 201.20 (a)(c) Staff development.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395948	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER: Rehabilitation Center at Jefferson Hills, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 540 Coal Valley Road Jefferson Hills, PA 15025	

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 0944 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on Quality Assurance and Performance Improvement (QAPI) for eleven of fifteen staff members (Employee E5, E6, E7, E8, E9, E10, E11, E12, E13, E14, and E15).Findings include: Review of the facility policy, Staff Development Program most recently reviewed 12/5/25, indicated, There shall be an ongoing coordinated education program which is planned and conducted for the development and improvement of skills of the facility personnel, including training related to technology, problems, needs and rights of residents Review of facility provided documents and training records revealed the following staff members did not have documented training on the QAPI Program. Nurse Aide Employee E5 had a hire date of 10/24/25, and failed to have QAPI education upon hire or thereafter.Nurse Aide Employee E6 had a hire date of 11/23/25, and failed to have QAPI education upon hire or thereafter.Nurse Aide Employee E7 had a hire date of 2/5/24, failed to have QAPI in-service education between 2/5/25, and 2/5/26.Nurse Aide Employee E8Licensed Practical Nurse Employee E9 had a hire date of 11/24/25, and failed to have QAPI education upon hire or thereafter.Licensed Practical Nurse Employee E10 had a hire date of 1/29/24, failed to have QAPI in-service education between 1/29/25, and 1/29/26.Registered Nurse Employee E11 had a hire date of 1/14/16, failed to have QAPI in-service education between 1/14/25, and 1/14/26.Therapy Employee Employee E12 had a hire date of 12/12/22, failed to have QAPI in-service education between 12/12/25, and 12/12/26.Therapy Employee Employee E13 had a hire date of 12/18/23, failed to have QAPI in-service education between 12/18/25, and 12/18/26.Dietary Employee E14 had a hire date of 12/6/25, and failed to have QAPI education upon hire or thereafter.Environmental Services Employee E15 had a hire date of 12/26/23, failed to have QAPI in-service education between 12/26/25, and 12/26/26. During an interview on 2/13/26, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on QAPI for eleven of fifteen staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.18 (b)(1) Management.28 Pa Code: 201.20 (a)(c) Staff development.