

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395289	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/10/2025
NAME OF PROVIDER OR SUPPLIER: WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 VILLAGE DRIVE CANONSBURG, PA 15317		
STATE LICENSE NUMBER: 193302				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on February 10, 2025, at WeCare at South Hills Rehabilitation and Wellness Center, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.



Certified End Page

WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 193302

SURVEY EXIT DATE: 02/10/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

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K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 193302 Component 01 Main Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on February 10, 2025, it was determined that Wecare at South Hills Rehabilitation and Nursing Center was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a one-story, Type II (000), unprotected noncombustible building, with a basement, that is fully sprinklered.</p>	K 0000		

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K 0211 SS=D	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K 0211	1. Facility replaced the missing doorknob on the door leading to the medical records hallway. 2. The maintenance/designee will complete a weekly door audit on all doors for two months. Audits will continue annually. 3. The Nursing Home Administrator/designee will educate maintenance staff to ensure all egress doors have doorknobs and that all egress doors can properly close/open. 4. Any concerns will be reviewed during the Quality Assurance Performance Improvement committee.	Completion Date: 03/27/2025 Status: APPROVED Date: 02/28/2025

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K 0211 SS=D	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain means of egress to be free of all obstructions for full use in case of emergency in one instance, affecting one of five smoke compartments. Findings include: 1. Observation on February 10, 2025, at 10:40 a.m., revealed there was a missing door knob on the doors leading to the Medical Records hallway. The missing door knob made egress impossible when these doors are closed. Interview with the Facility Administrator and the Maintenance Director on February 10, 2025, at 12:30 p.m., confirmed the listed means of egress deficiency.	K 0211		

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K 0291 SS=C	<p>NFPA 101 Emergency Lighting</p> <p>Emergency Lighting</p> <p>Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0291	<ol style="list-style-type: none"> 1. The facility will conduct the monthly 30 second testing of the battery back-up lighting for 12 out of the 12 months. 2. The facility will conduct an annual 90-minute test of the battery backup lighting. 3. The Nursing Home Administrator/designee will educate maintenance staff to ensure all battery back-up lighting. 4. The maintenance staff/designee will audit weekly for two months and then monthly for two months to ensure the monthly back-up lighting for the facility is completed. 5. Any concerns will be reviewed during the Quality Assurance Performance Improvement committee. 	<p>Completion Date: 03/27/2025</p> <p>Status: APPROVED</p> <p>Date: 02/28/2025</p>

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K 0291 SS=C	Continued from page 4 Based on documentation review and interview, it was determined the facility failed to maintain emergency lighting in two instances, affecting the entire facility. Findings Include: 1. Documentation review on February 10, 2025, revealed the facility lacked the following emergency lighting testing documentation: a) 8:30 a.m., monthly 30 second tests of the battery backup lighting for 12 of 12 months; b) 8:31 a.m., an annual 90 minute test of the battery backup lighting performed in the last 12 months. Interview with the Facility Administrator and Maintenance Director on February 10, 2025, at 12:30 p.m., confirmed the facility lacked the emergency light testing documentation at the time of the survey.	K 0291		

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K 0291 SS=C	Continued from page 5	K 0291		
K 0293 SS=C	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by:	K 0293	1. The Maintenance Director/ Designee will conduct monthly exit sign inspections for all exit signs for 12 out of 12 months. 2. The Nursing Home Administrator/designee will educate the maintenance staff on monthly inspection of all exit signs in the facility. 3. The maintenance staff/designee will audit weekly for two months and then monthly for two months to ensure monthly inspections of all exit signs in the facility are being completed. 4. Any concerns will be brought to the Quality Assurance Performance Improvement Committee for review.	Completion Date: 03/27/2025 Status: APPROVED Date: 02/28/2025

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K 0293 SS=C	Continued from page 6 Based on document review and interview, it was determined the facility failed to perform monthly exit sign inspections for five of 12 months, affecting the entire facility. Findings Include: 1. Document review on February 10, 2025, at 8:55 a.m., revealed the facility lacked documentation for the monthly exit sign inspections for five of the last 12 months. Interview with the Facility Administrator and Maintenance Director on February 10, 2025, at 12:30 p.m., confirmed the lack of documentation at the time of the survey.	K 0293		
K 0321 SS=E		K 0321		

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K 0321 SS=E	Continued from page 8 This REQUIREMENT is not met as evidenced by:	K 0321		

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K 0321 SS=E	Continued from page 9 Based on observation and interview, it was determined the facility failed to maintain hazardous area enclosures in one instance, affecting one of five smoke compartments. Findings include: 1. Observation on February 10, 2025, at 10:10 a.m., revealed the doors to the Condensing Room would not close and latch. Interview with the Facility Administrator and Maintenance Director, on February 10, 2025, at 12:30 p.m., confirmed the door in the hazardous area enclosure failed to latch.	K 0321		

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K 0321 SS=E	Continued from page 10	K 0321		
K 0324 SS=E	<p>NFPA 101 Cooking Facilities</p> <p>Cooking Facilities</p> <p>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:</p> <ul style="list-style-type: none"> * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0324	<ol style="list-style-type: none"> 1. The Maintenance Director/Designee will conduct the monthly inspection of the kitchen fire suppression system to be in compliance with NFPA. 2. The Nursing Home Administrator/designee will educate the maintenance staff on monthly inspection of the kitchen fire suppression system. 3. The maintenance staff/designee will audit weekly for two months and then monthly for two months to ensure the monthly inspection of the fire suppression system is being completed. 4. Any concerns will be brought to the Quality Assurance Performance Improvement Committee for review. 	<p>Completion Date: 03/27/2025</p> <p>Status: APPROVED</p> <p>Date: 02/28/2025</p>

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K 0324 SS=E	Continued from page 11 Based on documentation review, observation, and interview, it was determined the facility failed to perform twelve of twelve monthly kitchen fire suppression system inspections, affecting one of five smoke compartments. Findings include: 1. Document review and observation on February 10, 2025, at 10:55 a.m., revealed there was no documentation for monthly inspections of the kitchen fire suppression system. Interview with the Facility Administrator and Maintenance Director on February 10, 2025 at 12:30 p.m., confirmed the facility lacked documentation for the monthly kitchen fire suppression system visual inspections.	K 0324		

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K 0353 SS=F	<p>NFPA 101 Sprinkler System - Maintenance and Testing</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0353	<ol style="list-style-type: none"> The Facility will schedule the three-year Full Flow Trip Test of the dry pipe sprinkler system. The facility will replace the missing ceiling tiles in the laundry room, in the staff development/medical records room, in the kitchen and in the A-wing utility room. The gaps in the ceiling tile in the C-Wing Utility closet greater than 1/8 inch will be repaired/replaced as needed. The maintenance staff will be in-serviced on Sprinkler system Maintenance and Testing. The Maintenance staff/designee will do facility rounds to ensure all ceilings tiles are intact and that there are no gaps that are greater than 1/8 inches and will report any concerns to the Quality Assurance Performance improvement committee. The Safety Committee will review the repairs to ensure all corrections are made. 	<p>Completion Date: 03/27/2025</p> <p>Status: APPROVED</p> <p>Date: 03/03/2025</p>

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K 0353 SS=F	Continued from page 13 Based on observation, document review, and interview, it was determined the facility failed to maintain the automatic sprinkler system in six instances, affecting the entire facility. Findings include: 1. Observation and document review on February 10, 2025, revealed the following automatic sprinkler system deficiencies: a) 9:01 a.m., the facility failed to provide documentation for the three-year Full Flow Trip Test of the dry pipe sprinkler system; b) 9:03 a.m., there were two missing ceiling tiles in the Laundry room which could affect operation of the automatic sprinkler system; c) 9:05 a.m., there was a missing ceiling tile in the Staff Development/Medical records room; d) 9:15 a.m., there were two missing ceiling tiles in the kitchen; e) 9:25 a.m., there was a missing ceiling tile in the	K 0353		

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K 0353 SS=F	Continued from page 14 A-Wing utility room; f) 9:45 a.m., there was a gap larger than 1/8 inch in a ceiling tile, inside the C-Wing Electrical Room. Interview with the Facility Administrator and Maintenance Director on February 10, 2025, at 12:30 p.m., confirmed the above listed automatic sprinkler system deficiencies.	K 0353		
K 0355 SS=E		K 0355		

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K 0355 SS=E	Continued from page 15 NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by:	K 0355	1. The Maintenance Director/designee will conduct the monthly inspection of all fire extinguishers that are located in the facility. 2. The Fire Extinguisher that was missing during the annual inspection, will be inspected/repared for the annual inspection. 3. The Nursing Home Administrator/designee will educate the maintenance staff on monthly inspection of all fire extinguishers located in the facility. 4. The maintenance staff/designee will audit weekly for two months and then monthly for two months to ensure that monthly inspection of all fire extinguishers is being completed. 5. Any concerns will be brought to the Quality Assurance Performance Improvement Committee for review.	Completion Date: 03/27/2025 Status: APPROVED Date: 03/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395289	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/10/2025
NAME OF PROVIDER OR SUPPLIER: WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 VILLAGE DRIVE CANONSBURG, PA 15317		
STATE LICENSE NUMBER: 193302				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0355 SS=E	Continued from page 16 Based on observation and interview, it was determined the facility failed to maintain portable fire extinguishers in one instance, affecting one of five smoke compartments. Findings include: 1. Observation on February 10, 2025, at 9:30 a.m., revealed the facility failed to perform the required annual inspection for the fire extinguisher in the Activities Room. Interview with the Facility Administrator and Maintenance Director on February 10, 2025, at 12:30 p.m., confirmed the above portable fire extinguisher deficiency.	K 0355		
K 0363 SS=E		K 0363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395289	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/10/2025
NAME OF PROVIDER OR SUPPLIER: WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 VILLAGE DRIVE CANONSBURG, PA 15317		
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K 0363 SS=E	Continued from page 17 NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 0363	1. The facility immediately corrected the door to B-Wing Room 301 by removing the isolation bag that was hanging over the door. The door can close and latch when tested. 2. The Nursing Home Administrator/designee will educate staff to ensure any door with isolation bags, are not a barrier for the fire doors to close and latch. 3. The maintenance staff/designee will audit weekly for two months and then monthly for two months to ensure that no doors are blocked from closing or latching. 4. Any concerns will be brought to the Quality Assurance Performance Improvement Committee for review.	Completion Date: 03/27/2025 Status: APPROVED Date: 02/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395289	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/10/2025
NAME OF PROVIDER OR SUPPLIER: WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 VILLAGE DRIVE CANONSBURG, PA 15317		
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K 0363 SS=E	Continued from page 18 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	K 0363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395289	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/10/2025
NAME OF PROVIDER OR SUPPLIER: WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 VILLAGE DRIVE CANONSBURG, PA 15317		
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K 0363 SS=E	Continued from page 19 Based on observation and interview, it was determined the facility failed to maintain corridor doors in one instance, affecting one of five smoke compartments. Findings include: 1. Observation on February 10, 2025, at 11:30 a.m., revealed the door to B-wing Room 301 would not close and latch when tested. Interview with the Facility Administrator and Maintenance Director on February 10, 2025, at 12:30 p.m., confirmed the door failed to latch when tested.	K 0363		
K 0712 SS=F		K 0712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395289	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/10/2025
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K 0712 SS=F	Continued from page 20 NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by:	K 0712	1. Facility cannot retroact fire drills from those that were missing from the second quarter of the year for third shift, the first, second and third shifts in the third quarter and the third shift in the fourth quarter. 2. Facility will create a yearly plan for fire drills for every shift for every quarter. 3. The maintenance staff/designee will audit weekly for two months and then monthly for two months to ensure all fire drills are being conducted. 4. Any concerns will be brought to the Quality Assurance Performance Improvement Committee for review.	Completion Date: 03/27/2025 Status: APPROVED Date: 02/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395289	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/10/2025	
NAME OF PROVIDER OR SUPPLIER: WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 193302		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 VILLAGE DRIVE CANONSBURG, PA 15317		
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K 0712 SS=F	Continued from page 21 Based on documentation review and interview, it was determined the facility failed to perform five of twelve required fire drills, affecting the entire facility. Findings include: 1. Review of documentation on February 10, 2025, at 8:15 a.m., revealed the facility lacked fire drill documentation for: a) A fire drill performed in the second quarter of the year for third shift; b) the first, second, and third shifts in the third quarter; c) the third shift in the fourth quarter. Interview with the Facility Administrator and Maintenance Director on February 10, 2025, at 12:30 p.m., confirmed the facility lacked documentation for these listed fire drills performed in the previous twelve months.	K 0712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395289	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/10/2025
NAME OF PROVIDER OR SUPPLIER: WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 VILLAGE DRIVE CANONSBURG, PA 15317		
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K 0712 SS=F	Continued from page 22	K 0712		
K 0761 SS=C	<p>NFPA 101 Maintenance, Inspection & Testing - Doors</p> <p>Maintenance, Inspection & Testing - Doors</p> <p>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.</p> <p>Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.</p> <p>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.</p> <p>Written records of inspection and testing are maintained and are available for review.</p> <p>19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80)</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0761	<p>1. The Maintenance Director/designee will conduct the annual fire door assembly inspection.</p> <p>2. The Nursing Home Administrator/designee will educate the maintenance staff on the annual fire door assembly inspection.</p> <p>3. The maintenance staff/designee will audit the Life Safety Audit Documentation form to ensure the facility is in compliance with the annual fire door assembly inspection.</p> <p>4. Any concerns will be brought to the Quality Assurance Performance Improvement Committee for review.</p>	<p>Completion Date: 03/27/2025</p> <p>Status: APPROVED</p> <p>Date: 02/28/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395289	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/10/2025	
NAME OF PROVIDER OR SUPPLIER: WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 193302		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 VILLAGE DRIVE CANONSBURG, PA 15317		
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K 0761 SS=C	Continued from page 23 Based on documentation review and interview, it was determined the facility failed to perform the required annual fire door assembly inspection, affecting the entire facility. Findings include: 1. Review of documentation on February 10, 2025, at 9:15 a.m., revealed the facility lacked documentation for an annual fire door assembly inspection. Interview with the Facility Administrator and Maintenance Director on February 10, 2025, at 12:30 p.m., confirmed the facility lacked documentation, at the time of the survey, showing that an annual fire door assembly inspection had been completed.	K 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395289	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/10/2025
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K 0912 SS=D	<p>NFPA 101 Electrical Systems - Receptacles</p> <p>Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0912	<ol style="list-style-type: none"> 1. The electrical receptacle in question will be replaced with a GFCI receptacle. 2. The maintenance staff will be in-serviced on Electrical System receptacles. 3. The Maintenance staff/designee will audit for any receptacles within 6 feet of sink that are not GFCI protected and report any concerns to the Quality Assurance Performance improvement committee. 4. The Safety Committee will review the repair to ensure all corrections are made. 	<p>Completion Date: 03/27/2025 Status: APPROVED Date: 02/28/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395289	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/10/2025
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K 0912 SS=D	Continued from page 25 Based on observation and interview, it was determined the facility failed to maintain electrical receptacles in one instance, for one of over thirty receptacles inspected. Findings include: 1. Observation on February 10, 2025, at 10:23 a.m., revealed an electrical outlet, located within six feet of a sink in the A Wing Pantry was not protected by ground fault circuit interrupter (GFCI). Interview with the Facility Administrator and Maintenance Director on Febraury 10, 2025, at 12:30 p.m., confirmed the above electrical receptacle deficiency.	K 0912		
K 0918 SS=F		K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395289	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/10/2025	
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K 0918 SS=F	Continued from page 26 NFPA 101 Electrical Systems - Essential Electric System Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10	K 0918	1. The Maintenance Director/designee will conduct the weekly visual inspection to ensure the facility is in compliance. 2. The Maintenance Director/designee will conduct the monthly conductance testing to ensure the facility is in compliance. 3. The Nursing Home Administrator/designee will educate the maintenance staff on visual inspection and conductance testing on the generator to ensure the facility is in compliance. 4. The maintenance staff/designee will audit weekly for two months and then monthly for two months to ensure all generator testing is completed. 5. Any concerns will be brought to the Quality Assurance Performance Improvement Committee for review.	Completion Date: 03/27/2025 Status: APPROVED Date: 02/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395289	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/10/2025
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NAME OF PROVIDER OR SUPPLIER: WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 193302	STREET ADDRESS, CITY, STATE, ZIP CODE: 201 VILLAGE DRIVE CANONSBURG, PA 15317
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K 0918 SS=F	Continued from page 27 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918		

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K 0918 SS=F	Continued from page 28 Based on documentation review and interview, it was determined the facility failed to maintain the emergency generator in two instances, affecting the entire facility. Findings include: 1. Review of documentation on February 10, 2025, revealed the following emergency generator deficiencies: a) 8:50 a.m., the facility failed to provide documentation for the weekly visual inspection; b) 8:52 a.m., the facility failed to provide documentation for the monthly conductance testing. Interview with the Facility Administrator and Maintenance Director on February 10, 2025, at 12:30 p.m., confirmed the above listed emergency generator deficiencies.	K 0918		

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K 0919 SS=E	NFPA 101 Electrical Equipment - Other Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567, Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0919	1. Maintenance will conduct a daily audit for 2 weeks of all custodial rooms to ensure nothing is stored in the allowable space for electric panels. 2. The Nursing Home Administrator/designee will educate housekeeping staff on proper storing of housekeeping carts. Education will be documented. 3. The Housekeeping Supervisor/designee will continue weekly audits for two months, then bi-weekly for two months. 4. Education will be provided when deficiencies are found. 5. Any concerns will be brought to the Quality Assurance Performance Improvement Committee for review.	Completion Date: 03/27/2025 Status: APPROVED Date: 02/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395289	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/10/2025
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K 0919 SS=E	Continued from page 30 Based on observation and interview, it was determined the facility failed to maintain electrical equipment in two instances, affecting two of five smoke compartments, per NFPA 99 2012 Edition, Chapter 10.1.1 Findings include: 1. Observation on February 10, 2025, revealed access to the following electrical panels was blocked by miscellaneous housekeeping materials storage: a) 10:34 a.m., in the custodial room, D-Wing; b) 10:41 a.m., in the custodial room, E-Wing. Interview with the Facility Administrator and the Maintenance Director on February 10, 2025, at 12:30 p.m., confirmed the listed electrical equipment deficiencies.	K 0919		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0919 SS=E	Continued from page 31	K 0919		
K 0920 SS=E	<p>NFPA 101 Electrical Equipment - Power Cords and Extens</p> <p>Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0920	<ol style="list-style-type: none"> Maintenance will conduct a weekly audit on extension/power strip cords throughout the facility. Nursing Home Administrator/designee will be educated on the use of power strips/extension cords. The audit will be ongoing throughout the calendar year. When a deficiency is found, staff will be educated, and cord will be removed. Any concerns will be brought to the Quality Assurance Performance Improvement Committee for review. 	<p>Completion Date: 03/27/2025 Status: APPROVED Date: 02/28/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395289	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/10/2025	
NAME OF PROVIDER OR SUPPLIER: WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 193302		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 VILLAGE DRIVE CANONSBURG, PA 15317		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0920 SS=E	Continued from page 32 Based on observation and interview, it was determined the facility failed to maintain electrical wiring systems and equipment in one instance, affecting one of five smoke compartments. Findings include: 1. Observation on February 10, 2025, at 10:15 a.m., revealed there was a power strip/surge protector being used as a permanent junction box in the Mechanical/Electrical room in the basement. Interview with the Facility Administrator and Maintenance Director on February 10, 2025, at 12:30 p.m., confirmed the listed electrical wiring systems deficiency.	K 0920		



Certified End Page

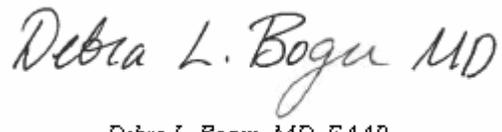
WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 193302

SURVEY EXIT DATE: 02/10/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY