STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395289	A. BLDG: 00 B. WING:	09/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **193302**	**201 VILLAGE DRIVE CANONSBURG, PA 15317**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F 0000	INITIAL COMMENT Based on an Abbreviated Survey in response to four complaints, and an incident completed on September 30, 2025, it was determined that Wecare at South Hills Rehabilitation and Nursing Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0569 SS=E		F 0569		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0569 SS=E	Continued from page 1 483.10(f)(10)(iv)(v) Notice and Conveyance of Personal Funds §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by:	F 0569	The facility cannot correct the past Resident Refunds for R1 who expired 5/5/25 and R2 who expired 5/21/25. The facility will ensure all resident funds for residents who expired/discharged are refunded within the 30 day requirement. Business Office Manager and Wellsky Representative will be re-educated by Administrator on ensuring resident funds are refunded within 30 days of discharge/expired. Daily Business Office Meetings will be held by administration to review discharges and confirm if refund has been processed by facility and Wellsky. The Nursing Home Administrator/designee will audit resident fund accounts for discharges daily for one month, then monthly for 3 months to ensure requirements are being met. Outcomes will be reported to the	Completion Date: **11/24/2025** Status: **APPROVED** Date: **11/07/2025**

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F 0569 SS=E	Continued from page 2	F 0569	Quality Assurance Performance Improvement Committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0569 SS=E	Continued from page 3 Based on a review of clinical records and residents' financial account records and staff interview, it was determined that the facility failed to return resident funds within 30 days of discharge/death to the appropriate party for one of five residents sampled (Resident R1 and Resident R2). Findings include: Review of the clinical record indicated Resident R1 was admitted to the facility on 4/25/25, with diagnoses that included cancer, high blood pressure, and diabetes. Review of facility documents revealed Resident R1 expired (passes away) on 5/5/25, at 6:41 a.m. During an interview on 9/30/25, at 12:30 p.m. Business Office Employee E1 stated the facility does not handle billing on site, the company uses the third-party company "Wellsky". They stated, as of 9/30/25, Resident R1's responsible party was due a refund of $385.00. Review of an email provided by Business Office Employee E1, indicated Resident R1's family contacted the facility on 9/30/25, at 12:22 p.m. to inquire about the refund owed. The family had made previous inquiries regarding the refund. Review of the clinical record indicated Resident R2 was admitted to the facility on 5/1/25, with diagnoses that included diabetes, cerebral infarction (blood flow to the	F 0569		

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F 0569 SS=E	Continued from page 4 brain is obstructed by a blood clot resulting in death of brain cells), and high blood pressure. Review of facility documents revealed Resident R2 expired on 5/21/25, at 1:15 a.m. During an interview on 9/30/25, at 12:35 p.m. Business Office Employee E1 stated Resident R2's responsible party was due a refund of $2530.00. They stated the refund was processed on 8/4/25, by Wellsky. The facility was unable to provide a copy of the check or bank statement showing it was cashed. During an interview on 9/30/25, at 2:00 p.m., the Business Office Employee E1 verified that Resident R1's and Resident R2's personal funds were not refunded to the family within 30 days of his discharge/death from the facility.	F 0569		

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P 5520		P 5520		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 1 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	The facility cannot correct that the nurse aide staffing ratio was not meet on the day shift on seventeen of twenty one days (8/26/25 thru 9/15/2025) one NA per 11 resident on evening shift on twelve of twenty one days (8/29/25 thru 9/1/25 and 9/5/25 thru 9/15/25) one NA per 15 residents on the night shift on six of twenty one days (9/6, 9/9, 9/10, 9/12. 9/13 and 9/15/25) as required. There were no adverse effects to the residents on the identified dates. 2. The facility will ensure that staffing ratios are met every shift. 3. Nursing administration and the nursing scheduler will be re-educated by the Nursing Home Administrator/designee on ensuring staffing ratios are met each shift. A Daily staffing meeting will be held by administration to monitor staffing ratios. Nursing supervisors will monitor on weekends. If the facility is projected to not meet staffing ratios the scheduler/or designee will call off duty facility staff and will	Completion Date: **11/24/2025** Status: **APPROVED** Date: **11/07/2025**

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P 5520	Continued from page 2	P 5520	utilize external staffing support resources. 4. The Nursing Home Administrator/designee will audit staffing daily for three weeks and monthly for three months to ensure staffing ratios are being met. Outcomes will be reported to the Quality Assurance Performance Improvement Committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 3 Based on review of nursing time schedules and staff interview it was determined that the facility administrative staff failed to provide a minimum of one nurse aide (NA) per 12 residents during the day and/or evening shift, and/or one nurse aid per 20 residents during the night shift for 20 of 21 days (8/26/25, 8/27/25, 8/29/25, 8/30/25, 8/31/25, 9/1/25, 9/2/25, 9/3/35, 9/4/25, 9/5/25, 9/6/25, 9/7/25, 9/8/25, 9/9/25, 9/10/25, 9/11/25, 9/12/25, 9/13/25, 9/14/25, and 9/15/25). Findings include: Review of the facility census data, nursing time schedules, and deployment sheets revealed the following nurse aide staffing shortages: On 8/26/25, census 66. Day shift needed 6.60 NAs, facility provided 6.23. On 8/27/25, census 64. Day shift needed 6.40 NAs, facility provided 6.22. On 8/29/25, census 68. Day shift needed 6.80 NAs, facility provided 6.47. On 8/29/25, census 68. Afternoon shift needed 6.18 NAs, facility provided 4.64. On 8/30/25, census 68. Day shift required 6.80 NAs, facility provided 6.30. On 8/30/25, census 68. Afternoon shift required 6.18 NAs, facility provided 4.69. On 8/31/25, census 68. Day shift required 6.80 NAs, facility provided 6.05.	P 5520		

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P 5520	Continued from page 4 On 8/31/25, census 65. Afternoon shift required 5.91 NAs, facility provided 5.78. On 9/1/25, census 68. Day shift required 6.80 NAs, facility provided 6.05. On 9/1/25, census 68. Afternoon shift required 6.18 NAs, facility provided 5.78. On 9/2/25, census 68. Day shift required 6.80 NAs, facility provided 6.17. On 9/3/25, census 68. Day shift required 6.80 NAs, facility provided 6.40. On 9/4/25, census 64. Day shift required 6.40 NAs, facility provided 5.34. On 9/5/25, census 65. Afternoon shift required 5.91 NAs, facility provided 5.20. On 9/6/25, census 65. Day shift required 6.50 NAs, facility provided 6.34. On 9/6/25, census 65. Afternoon shift required 5.91 NAs, facility provided 4.71. On 9/6/25, census 65. Night shift required 4.33 NAs, facility provided 3.73. On 9/7/25, census 67. Day shift required 6.70 NAs, facility provided 4.85. On 9/7/25, census 67. Afternoon shift required 6.09 NAs, facility provided 4.17. On 9/7/25, census 67. Night shift required 4.47 NAs, facility provided 3.22. On 9/8/25, census 67. Day shift required 6.70 NAs, facility provided 6.27. On 9/8/25, census 67. Afternoon shift required 6.09 NAs,	P 5520		

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P 5520	Continued from page 5 facility provided 5.87. On 9/9/25, census 68. Day shift required 6.80 NAs, facility provided 5.91. On 9/9/25, census 68. Afternoon shift required 6.18 NAs, facility provided 5.34. On 9/9/25, census 68. Night shift required 4.53 NAs, facility provided 4.26. On 9/10/25, census 68. Day shift required 6.80 NAs, facility provided 5.90. On 9/10/25, census 68. Afternoon shift required 6.18 NAs, facility provided 5.78. On 9/10/25, census 68. Night shift required 4.53 NAs, facility provided 4.35. On 9/11/25, census 68. Afternoon shift required 6.18, facility provided 5.31. On 9/12/25, census 67. Afternoon shift required 6.09 NAs, facility provided 4.38. On 9/12/25, census 67. Night shift required 4.47 NAs, facility provided 3.83. On 9/13/25, census 67. Day shift required 6.70 NAs, facility provided 4.40. On 9/13/25, census 67. Afternoon shift required 6.09 NAs, facility provided 4.58. On 9/13/25, census 67. Night shift required 4.47 NAs, facility provided 4.35. On 9/14/25, census 67. Day shift required 6.70 NAs, facility provided 4.73. On 9/14/25, census 66. Night shift required 4.40 NAs, facility provided 3.44.	P 5520		

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P 5520	Continued from page 6 On 9/15/25, census 66. Day shift required 6.60 NAs, facility provided 6.46. On 9/15/25, census 66. Afternoon shift required 6.00 NAs, facility provided 4.70. On 9/15/25, census 66. Night shift required 4.40 NAs, facility provided 4.24. During an interview on 9/30/25, at 2:30 p.m. the Director of Nursing confirmed that the facility failed to provide a minimum of one nurse aide per 12 residents during the day and evening shift, and/or one nurse aid per 20 residents during the night shift on 20 of 21 days.	P 5520		
P 5640		P 5640		

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P 5640	Continued from page 7 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	The facility cannot correct that the PPDs were not met on 8/29, 8/30, 9/5, 9/6, 9/7, 9/8, 9/9, 9/10, 9/12, 9/13, 9/14, and 9/15. There were no adverse effects to the residents on the identified date. 2. The facility will ensure that staffing ratios are met every shift. 3. Nursing administration and the nursing scheduler will be re-educated by the Nursing Home Administrator/designee on ensuring PPDs are met for the day. A Daily staffing meeting will be held by administration to monitor PPD levels. Nursing supervisors will monitor on weekends. If the facility is projected to not meet PPD, the scheduler/or designee will call off duty facility staff and will utilize external staffing support resources. 4. The Nursing Home Administrator/designee will audit staffing daily for three weeks and monthly for three months to ensure PPDs are met. Outcomes will be	Completion Date: **11/24/2025** Status: **APPROVED** Date: **11/07/2025**

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P 5640	Continued from page 8	P 5640	reported to the Quality Assurance Performance Improvement Committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 9 Based on review of nursing time schedules and staff interviews it was determined that the facility administrative staff failed to provide the minimum number of general nursing hours to each resident in a 24 hour period on 13 of 21 days (8/29/25, 8/30/25, 9/5/25, 9/6/25, 9/7/25, 9/8/25, 9/9/25, 9/10/25, 9/11/25, 9/12/25, 9/13/25, 9/14/25, 9/15/25). Findings include: Nursing time schedules form 8/26/25 through 9/15/25, revealed that the facility failed to maintain 3.20 hours of general nursing care to each resident in a 24-hour period on the following dates: -8/29/25, PPD 2.93 -8/30/25, PPD 2.85 -9/5/25, PPD 3.15 -9/6/25, PPD 2.83 -9/7/25, PPD 2.43 -9/8/25, PPD 2.93 -9/9/25, PPD 3.03 -9/10/25, PPD 2.93 -9/12/25, PPD 2.99 -9/13/25, PPD 2.59 -9/14/25, PPD 2.73 -9/15/25, PPD 3.00 During an interview on 9/30/25, at 2:30 p.m. the Director of Nursing confirmed the facility failed to provide the	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **193302**	**201 VILLAGE DRIVE CANONSBURG, PA 15317**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
P 5640	Continued from page 10 minimum number of general nursing hours to each resident in a 24-hour period on 13 of 21 days.	P 5640		

Certified End Page

WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 193302

SURVEY EXIT DATE: 09/30/2025

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
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