PRINTED: 11/21/2025 FORM APPROVED 2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)  (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:  09/30/2025			
WECARE .	VIDER OR SUPPLIER: AT SOUTH HILLS REHA SING CENTER	395289 BILITATION	201 VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE: 201 VILLAGE DRIVE CANONSBURG, PA 15317				
STATE LICENS	e number: <b>193302</b>							
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0000  F 0569  SS=E	Based on an Abbreviated S complaints, and an incident 2025, it was determined that Rehabilitation and Nursing with the following requirent Subpart B, Requirements for the 28 Pa. Code, Commony Term Care Licensure Regulation Car	t completed on Septemb at Wecare at South Hills Center was not in compnents of 42 CFR Part 48 or Long Term Care Faci wealth of Pennsylvania I lations.	er 30, pliance 3, lities and Long	F 0569	TITLE	(X6) DATE.		
LABORATORY I	DIRECTOR'S OR PROVIDER/SUPPLI	ER REPRESENTATIVE'S SIGN.	ATURE		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.

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

PLAN OF CORRECTION (POC) IDEN		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395289		B. WING: _		09/30/2025	
NAME OF PROVIDER OR SUPPLIER: WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER  STATE LICENSE NUMBER: 193302			201 VILLAGE CANONSBUE	E DRIVE			
(X4) ID PREFIX TAG	EFIX MUST BE PRECEEDED BY FULL REGULATORY AG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0569	Continued from page 1		F 0569				
SS=E	483.10(f)(10)(iv)(v) Notice Funds  §483.10(f)(10)(iv) Notice of The facility must notify each Medicaid benefits- (A) When the amount in the \$200 less than the SSI resous specified in section 1611(a) (B) That, if the amount in the value of the resident's other the SSI resource limit for or eligibility for Medicaid or S §483.10(f)(10)(v) Conveyar death.  Upon the discharge, eviction personal fund deposited with convey within 30 days the reaccounting of those funds, the death, the individual or probable the resident's estate, in accounting the resident's estate,	f certain balances. In resident that receives It resident's account reach receives It resident's account reach receives It resident's account reach receives It resident's account, and addition to account, in addition to anonexempt resources, received person, the resident means.  It resident means the facility account of a resident that the facility, the facility esident's funds, and a first the resident, or in the count jurisdiction administration with State law.	hes  to the eaches hay lose etion, or with a y must hal case of		The facility cannot correct the Resident Refunds for R1 who 5/5/25 and R2 who expired 5. The facility will ensure all refunds for residents who expired/discharged are refund within the 30 day requirement. Business Office Manager and Wellsky Representative will re-educated by Administrato ensuring resident funds are rewithin 30 days of discharge/discharges and confirm if refuse held by administration to discharges and confirm if refuse processed by facility and Wellsky.  The Nursing Home Administrator/designee will resident fund accounts for discharges daily for one more monthly for 3 months to ensure requirements are being met. Outcomes will be reported to	o expired 5/21/25. esident ded nt.  d be or on efunded expired.  ngs will review fund has nd audit audit nth, then ure	Completion Date: 11/24/2025 Status: APPROVED Date: 11/07/2025

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#### PRINTED: 11/21/2025 FORM APPROVED 2567-L

# DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:	ER:		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395289		A. BLDG: _ B. WING: _	00	09/30/2025	
NAME OF PROVIDER OR SUPPLIER: WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER  STATE LICENSE NUMBER: 193302			STREET ADDRESS, 201 VILLAGE CANONSBUE	E DRIVE			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEI PREFIX MUST BE PRECEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0569	Continued from page 2			F 0569			
SS=E					Quality Assurance Performa Improvement Committee for and recommendations.		

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)  (XI) PROVIDER/SUPPLIER. IDENTIFICATION NUMBER				(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395289		B. WING: _		09/30/2025	
NAME OF PROVIDER OR SUPPLIER:  WECARE AT SOUTH HILLS REHABILITATION  AND NURSING CENTER  STATE LICENSE NUMBER: 193302			STREET ADDRESS, 201 VILLAGE CANONSBUE	E DRIVE			
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0569 SS=E	Continued from page 3  Based on a review of clinic financial account records a determined that the facility within 30 days of discharge for one of five residents sar Resident R2).  Findings include:  Review of the clinical reco admitted to the facility on a included cancer, high blood Review of facility documer (passes away) on 5/5/25, at During an interview on 9/3 Office Employee E1 stated billing on site, the company "Wellsky". They stated, as responsible party was due at Review of an email provide E1, indicated Resident R1's 9/30/25, at 12:22 p.m. to in family had made previous in family had made previous included diabetes, cerebral	rd indicated Resident R1 4/25/25, with diagnoses of pressure, and diabetes. the facility does not har y uses the third-party core of 9/30/25, Resident R1 arefund of \$385.00.  The diagnoses of pressure of pressure, and diabetes. The facility does not har y uses the third-party core of 9/30/25, Resident R1 arefund of \$385.00.  The deby Business Office E is family contacted the facility about the refund of the pressure of the pre	s funds e funds e party  1 was that 1 expired  iness andle mpany 's  mployee acility on owed. The efund.  2 was anat	F 0569			

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)  (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER  395289			A. BLDG: _	IPLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 09/30/2025	EY	
NAME OF PROVIDER OR SUPPLIER:  WECARE AT SOUTH HILLS REHABILITATION  AND NURSING CENTER  STATE LICENSE NUMBER: 193302			STREET ADDRESS, 201 VILLAGE CANONSBUR	DRIVE			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0569 SS=E	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 a.m.  During an interview on 9/30/25, at 12:35 p.m. Business Office Employee E1 stated Resident R2's responsible par was due a refund of \$2530.00. They stated the refund wa 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 Busines 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.		ness ple party and was anable anowing business d the	F 0569			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)  (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00		(X3) DATE SURVEY COMPLETED:					
395289				B. WING: 09/30/2025						
WECARE .	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 MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE				
P 5520				P 5520						
LABORATORY I	DIRECTOR'S OR PROVIDER/SUPPLI	ER REPRESENTATIVE'S SIGN.	ATURE		TITLE:	(X6) DATE:				

State Form D1KD11 IF CONTINUATION SHEET Page 1 of 11

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 395289		(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00_ B. WING:		(X3) DATE SURVEY COMPLETED: 09/30/2025	
WECARE AND NURS	VIDER OR SUPPLIER: AT SOUTH HILLS REHA SING CENTER E NUMBER: 193302	BILITATION	STREET ADDRESS, 201 VILLAGE CANONSBUE	E DRIVE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF CORRECTION (EACH CORRECTION OF CORRECTI		OULD BE	(X5) COMPLETE DATE
P 5520	Continued from page 1  Nursing services.  (3) Effective July 1, 2024, a residents during the day, 1 r during the evening, and 1 m overnight.  This REGULATION is not	nurse aide per 11 resider urse aide per 15 resident	nts	P 5520	The facility cannot correct the nurse aide staffing ratio was meet on the day shift on several of twenty one days (8/26/25 9/15/2025) one NA per 11 resevening shift on twelve of two one days (8/29/25 thru 9/15/25) one NA residents on the night shift of twenty one days (9/6, 9/9, 9/9/13 and 9/15/25) as required were no adverse effects to the residents on the identified day. The facility will ensure the staffing ratios are met every.  3. Nursing administration and nursing scheduler will be re-educated by the Nursing Factorial Administrator/designee on estaffing ratios are met each so Daily staffing meeting will be administration to monitor staratios. Nursing supervisors we monitor on weekends. If the is projected to not meet staffing ratios the scheduler/or designated off duty facility staff and	not enteen thru esident on wenty 25 and a per 15 on six of (10, 9/12. d. There he he he he he he he hist.  at shift.  ad the  Home ensuring shift. A be held by haffing will facility fing nee will	Completion Date: 11/24/2025 Status: APPROVED Date: 11/07/2025

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)  (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00		(X3) DATE SURVEY COMPLETED:		
		395289		B. WING: 09/30/2025			
WECARE AND NURS	VIDER OR SUPPLIER: AT SOUTH HILLS REHAL SING CENTER E NUMBER: 193302	BILITATION	STREET ADDRESS, 201 VILLAGE CANONSBUR	DRIVE			
STATE LICENSE NUMBER: 193302  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORREC	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDE IDENTII	R LSC	PREFIX TAG	CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A		COMPLETE DATE	
P 5520	Continued from page 2			P 5520			
					utilize external staffing suppresources.  4. The Nursing Home Administrator/designee will staffing daily for three weeks monthly for three months to staffing ratios are being met. Outcomes will be reported to Quality Assurance Performal Improvement Committee for and recommendations.	audit s and ensure o the nce	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395289		_	00	09/30/2025	
WECARE AND NUR	VIDER OR SUPPLIER: AT SOUTH HILLS REHA SING CENTER SE NUMBER: 193302	BILITATION	STREET ADDRESS, 201 VILLAGE CANONSBUR	DRIVE			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY C IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
P 5520	Based on review of nursing interview it was determined staff failed to provide a min per 12 residents during the and/or one nurse aid per 20 for 20 of 21 days (8/26/25, 9/1/25, 9/2/25, 9/3/35, 9/4/9/9/25, 9/10/25, 9/11/25, 9/9/15/25).  Findings include:  Review of the facility cens and deployment sheets revestaffing shortages: On 8/26/25, census 66. Day provided 6.23. On 8/27/25, census 64. Day provided 6.22. On 8/29/25, census 68. Day provided 6.47. On 8/29/25, census 68. Aft facility provided 4.64. On 8/30/25, census 68. Day provided 6.30. On 8/30/25, census 68. Aft facility provided 4.69. On 8/31/25, census 68. Day provided 6.90. On 8/31/25, census 68. Day provided 6.05.	d that the facility admininimum of one nurse aided day and/or evening shift or residents during the nig 8/27/25, 8/29/25, 8/30/25, 9/5/25, 9/6/25, 9/14/25/12/25, 9/13/25, 9/14/25/25/25, 9/13/25, 9/14/25/25/25/25/25/25/25/25/25/25/25/25/25/	istrative e (NA) t, ght shift 25, 8/31/25, 5, 9/8/25, , and  nedules, e aide , facility , facility , facility 8 NAs, s, facility 18 NAs,	P 5520			

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		A. BLDG: _	IPLE CONSTRUCTION:	(X3) DATE SURVI COMPLETED: 09/30/2025	EY
NAME OF PROVIDER OR SUPPLIER: WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER			STREET ADDRESS, 201 VILLAGE CANONSBUR	DRIVE			
STATE LICENS	SE NUMBER: 193302						
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
P 5520	Continued from page 4			P 5520			
	On 8/31/25, census 65. Aft facility provided 5.78. On 9/1/25, census 68. Day provided 6.05. On 9/1/25, census 68. Afte facility provided 5.78. On 9/2/25, census 68. Day provided 6.17. On 9/3/25, census 68. Day provided 6.40. On 9/4/25, census 64. Day provided 5.34. On 9/5/25, census 65. Afte facility provided 5.20. On 9/6/25, census 65. Day provided 6.34. On 9/6/25, census 65. Afte facility provided 4.71. On 9/6/25, census 65. Nigh provided 3.73. On 9/7/25, census 67. Day provided 4.85. On 9/7/25, census 67. Afte facility provided 4.17. On 9/7/25, census 67. Nigh provided 3.22. On 9/8/25, census 67. Day provided 3.22. On 9/8/25, census 67. Day provided 3.22. On 9/8/25, census 67. Afte	shift required 6.80 NAs, shift required 6.80 NAs, shift required 6.80 NAs, shift required 6.40 NAs, shift required 6.40 NAs, rnoon shift required 5.91 shift required 6.50 NAs, rnoon shift required 5.91 at shift required 4.33 NA shift required 6.70 NAs, rnoon shift required 6.70 NAs, rnoon shift required 6.70 NAs, shift required 4.47 NA shift required 4.47 NA shift required 6.70 NAs, shift required 6.70 NAs, shift required 6.70 NAs,	s, facility  B NAs, s, facility				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)  (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER  395289			A. BLDG: _	IPLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 09/30/2025	EY				
	VIDER OR SUPPLIER: <b>AT SOUTH HILLS REHA</b>	DILITATION	STREET ADDRESS		ZIP CODE:					
	AT SOUTH HILLS KEHA SING CENTER	ABILITATION	201 VILLAGE DRIVE CANONSBURG, PA 15317							
				,						
	E NUMBER: <b>193302</b>			1	Г		г			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH D MUST BE PRECEEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH	· ·	(X5) COMPLETE			
TAG		IFYING INFORMATION)			CROSS-REFERENCED TO THE		DATE			
P 5520	Continued from page 5			P 5520						
1 3320	T.O.			F 3320						
	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. Afte	ernoon shift required 6.18	3 NAs,							
	facility provided 5.34.	-4 -1.10 1 1 4 52 NIA								
	On 9/9/25, census 68. Night provided 4.26.	it snift required 4.53 NA	s, facility							
	On 9/10/25, census 68. Day	v shift required 6.80 NA	s facility							
	provided 5.90.	y shift required 0.00 TVI	s, racinty							
	On 9/10/25, census 68. Aft	ternoon shift required 6.1	18 NAs,							
	facility provided 5.78.	•								
	On 9/10/25, census 68. Nig	ght shift required 4.53 N	As,							
	facility provided 4.35.									
	On 9/11/25, census 68. Aft	ternoon shift required 6.1	18,							
	facility provided 5.31. On 9/12/25, census 67. Aft	tornoon shift required 6 (	00 N A a							
	facility provided 4.38.	ternoon sinit required o.t	J9 INAS,							
	On 9/12/25, census 67. Nig	ght shift required 4.47 N	As,							
	facility provided 3.83.		,							
	On 9/13/25, census 67. Day	y shift required 6.70 NA	s, facility							
	provided 4.40.									
	On 9/13/25, census 67. Aft	ternoon shift required 6.0	99 NAs,							
	facility provided 4.58.									
	On 9/13/25, census 67. Nig	gnt shift required 4.47 N	As,			ļ				
	facility provided 4.35. On 9/14/25, census 67. Day	y shift required 6.70 NA	a facility							
	provided 4.73.	y siiiit iequileu 6.70 NA	s, racinty			ļ				
	On 9/14/25, census 66. Nig	oht shift required 4 40 N	As							
	facility provided 3.44.	5 5	,			ļ				
	J.1									

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:  A. BLDG: _00		(X3) DATE SURVEY COMPLETED:	
		395289			<u></u>	09/30/2025	
NAME OF PROVIDER OR SUPPLIER: WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER			STREET ADDRESS, 201 VILLAGE CANONSBUR	DRIVE			
STATE LICENSE NUMBER: 193302							
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
P 5520	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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)  (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			COMPLETE		(X3) DATE SURV COMPLETED:		
	395289			A. BLDG:00_ B. WING:		09/30/2025	
NAME OF PROVIDER OR SUPPLIER: WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER  STATE LICENSE NUMBER: 193302			STREET ADDRESS, 201 VILLAGE CANONSBUR	DRIVE			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIE PREFIX MUST BE PRECEEDED BY FULL REGULATORY OR LSC TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
P 5640	Continued from page 7  Nursing services.  (2) Effective July 1, 2024, the general nursing care provide when totaled for the entire fours of direct resident care.  This REGULATION is not	ed in each 24-hour perio acility, be a minimum o for each resident.	d shall,	P 5640	The facility cannot correct the PPDs were not met on 8/29, 9/6, 9/7, 9/8, 9/9, 9/10, 9/12, and 9/15. There were no adverfects to the residents on the identified date.  2. The facility will ensure the staffing ratios are met every  3. Nursing administration an nursing scheduler will be re-educated by the Nursing FAdministrator/designee on et PPDs are met for the day. A staffing meeting will be held administration to monitor PP Nursing supervisors will more weekends. If the facility is put to not meet PPD, the schedule designee will call off duty fastaff and will utilize external support resources.  4. The Nursing Home Administrator/designee will staffing daily for three weeks monthly for three months to PPDs are met. Outcomes will	8/30, 9/5, 9/13, 9/14, erse e  at shift. d the Home nsuring Daily by PD levels. nitor on rojected ler/or icility staffing  audit is and ensure	Completion Date: 11/24/2025 Status: APPROVED Date: 11/07/2025

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:	I) PROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
395289						09/30/2025		
WECARE AT SOUTH HILLS REHABILITATION			STREET ADDRESS, 201 VILLAGE CANONSBUR	DRIVE				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFIC PREFIX MUST BE PRECEEDED BY FULL REGULATORY OR L TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
P 5640	Continued from page 8			P 5640	reported to the Quality Assur Performance Improvement Committee for review and recommendations.	rance		

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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, 9/1/25, 9/18/25, 9/9/25, 9/10/25, 9/11/25, 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:	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00		(X3) DATE SURVEY COMPLETED:		
WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER  STATE LICENSE NUMBER: 193302  (X4) ID PREFIX TAG  CORRECTIVE ACTION SHOULD BE IDENTIFYING INFORMATION)  COMPLET DATE  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, 9/14/25, 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:	395289				B. WING: _		09/30/2025		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   DEFIX TAG   PREFIX TAG   CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   DATE    P 5640   Continued from page 9   P 5640    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, 9/12/25, 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:   DEFIX TAG   PROVIDERS PLAN OF CORRECTION (EACH CORRECTION	WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER			201 VILLAGE DRIVE					
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:	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION)					CORRECTIVE ACTION SH	HOULD BE	(X5) COMPLETE DATE	
-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 -9/8/25, 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	Based on review of nursing interviews it was determine staff failed to provide the nursing hours to each resid 21 days (8/29/25, 8/30/25, 9/9/25, 9/10/25, 9/11/25, 9/11/25, 9/11/25, 9/11/25, 9/11/25, 9/11/25, 9/11/25, 9/11/25, 9/11/25, 9/11/25, 9/11/25, 9/11/25, 9/11/25, PPD 2.93 -8/30/25, PPD 2.93 -9/6/25, PPD 2.83 -9/7/25, PPD 2.83 -9/7/25, PPD 2.93 -9/8/25, PPD 2.93 -9/10/25, PPD 3.00 During an interview on 9/3	Based on review of nursing time schedules and staff interviews it was determined that the facility admin staff failed to provide the minimum number of general nursing hours to each resident in a 24 hour period of 21 days (8/29/25, 8/30/25, 9/5/25, 9/6/25, 9/7/25, 9/9/25, 9/10/25, 9/11/25, 9/12/25, 9/13/25, 9/14/25, Findings include:  Nursing time schedules form 8/26/25 through 9/15/revealed that the facility failed to maintain 3.20 hour general nursing care to each resident in a 24-hour pron the following dates:  -8/29/25, PPD 2.93 -8/30/25, PPD 2.85 -9/5/25, 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 -9/10/25, PPD 2.93 -9/10/25, PPD 2.93 -9/10/25, PPD 2.93 -9/10/25, PPD 2.99 -9/13/25, PPD 2.59 -9/14/25, PPD 2.59 -9/14/25, PPD 2.73		P 5640				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)  (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:  395289			(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00  B. WING:		(X3) DATE SURVEY COMPLETED:  09/30/2025		
NAME OF PROVIDER OR SUPPLIER: WECARE AT SOUTH HILLS REHABILITATION AND NURSING CENTER  STATE LICENSE NUMBER: 193302			STREET ADDRESS, 201 VILLAGE CANONSBUR	DRIVE			
(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 CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(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				

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# **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, FAAP Secretary of Health

Debia L. Bogu MD



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY