Department of Health & Human Services Centers for Medicare & Medicaid Services

Printed: 06/01/2025 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395289	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/07/2024		
NAME OF PROVIDER OR SUPPLIER Wecare at South Hills Rehabilitation and Nrsg Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Village Drive Canonsburg, PA 15317			
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0760	Ensure that residents are free from significant medication errors.				
Level of Harm - Minimal harm or potential for actual harm	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311				
Residents Affected - Few	Based on review of facility policy, documents, clinical records, and staff interviews, it was determined th facility failed to ensure that residents were free from significant medication errors for one of three reside (Resident R1).				
	Findings include:				
	Review of facility policy Administering Medications 1/18/24, indicated medications are administered in a safe and timely manner, and as prescribed. The policy further stated that the individual administering the medication records in the resident's medical record: -the date and time the medication was administered;				
	-the dosage;				
	-the route of administration;				
	 -the injection site (if applicable); -any complaints or symptoms for which the drug was administered; -any results achieved and when those results were observed; and 				
	-the signature and title of the person administering the drug.				
	Review of Resident R1's admission record indicated he was originally admitted to the facility on [DATE], and readmitted on [DATE].				
	Review of Resident R1's Minimum Data Set (MDS - mandated assessment of a resident's abilities and care needs) dated 8/2/24, included diagnoses of epilepsy (disorder of the brain characterized by repeated seizures) and non-traumatic brain dysfunction.				
	Review of Resident R1's plan of care initiated 10/11/23, indicated Resident R1 is at risk for seizure activity. Included in the care plan interventions was, Medications as ordered.				
	(continued on next page)				

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

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 395289

If continuation sheet Page 1 of 3

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