

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

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>395208                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                 | (X3) DATE SURVEY<br>COMPLETED<br><br>12/17/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hillcrest Rehabilitation & Healthcare Center                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Little Drive<br>Lower Burrell, PA 15068 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                          |                                                 |
| F 0760<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, clinical record review, and interviews with staff, it was determined that the facility failed to ensure that residents are free of significant medication errors for one of five residents reviewed (Resident R1). Findings include: Review of facility policy Administering Medications dated 2/20/25, indicated medications are administered in a safe and timely manner, and as prescribed. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/17/25, indicated diagnoses of anemia (too little iron in the blood), high blood pressure, and Diabetes Mellitus (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of a physician order dated 10/13/25, indicated to administer insulin glargine (Lantus - a long-acting insulin given to lower blood sugar levels) inject 30 units subcutaneously (beneath the skin into the fatty tissue layer) at bedtime for diabetic. Review of a progress note dated 10/21/25, completed by Licensed Practical Nurse (LPN) Employee E1 stated, During night med pass this writer administered the resident the wrong insulin, writer administered 30 units humalog insulin (a rapid-acting insulin given to lower blood sugar levels) when the resident was to receive 30 units of lantus, writer immediately notified RN (Registered Nurse) supervisor of the error and physician notified, resident made aware of error as well as the residents contact and cousin, blood glucose at the time of incident 170, BP (blood pressure) 134/76, TPR (temperature) 97.5, 74 (heart rate), 98% RA (oxygen saturation on room air), writer immediately notified RN supervisor and physician called and orders received to monitor blood glucose q15 (every fifteen minutes) x 4. Then Q 1 hour x 4, resident given multiple snacks and a sandwich as well as milk and orange juice. Residents contact person as well as the resident notified of medication error. During an interview on 12/17/25, at 3:35 p.m. the Director of Nursing confirmed that the facility failed to ensure that residents are free of significant medication errors for one of five residents reviewed (Resident R1). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10 (c) Resident Care policies. 28 Pa. Code: 211.12 (d)(1)(5) Nursing services.</p> |                                                                                          |                                                 |

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.

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