STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395208	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Rehabilitation & Healthcare Center	100 Little Drive 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, facility policy, clinical record review, and staff interviews, it was determined that the facility failed to provide care and services needed for residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of three residents (Resident R1).Findings include: Review of facility policy Neurological Assessment last reviewed 2/20/25, indicated the purpose of the policy is to provide guidelines for a neurological assessment following an unwitnessed fall or subsequent to a fall with a suspected head injury. It was indicated to perform neurological checks with the frequency as ordered or per falls protocol. Document the date and time the procedure was performed, the name and title of the individual(s) who performed the procedure, all assessment data obtained, and the signature and title of the person recording the data. Review of the facility's undated Neurological Check Flowsheet indicated to document the date and time of each neurological check. The frequency unless specified my physician is every 15 minutes x4, every hour x2, and every four hours x4. 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 12/9/25, indicated diagnoses of malnutrition, non-Alzheimer's dementia, and adult failure to thrive. Review of Resident R1's progress note dated 12/12/25, revealed the resident was observed at 11:20 a.m. in front of door lying on right side of body. Bleeding noted to right frontal area previous area from prior fall. Area cleansed with normal saline solution (wound cleanser) bleeding stopped without difficulty. The resident was assessed by Nurse Practitioner, Employee E1. The resident's family and hospice were notified. The hospice physician ordered the resident to be sent to hospital for further evaluation of a head injury. A review of the resident's clinical record on 12/12/25, failed to reveal evidence neurological checks were performed after the resident had an unwitnessed fall. Review of Resident R1's progress note dated 12/12/25, at 1:04 p.m. revealed the resident was transferred to the hospital for further evaluation. During an interview on 2/11/26, at 10:38 a.m. the Director of Nursing (DON) confirmed there was no evidence the facility initiated neurological checks after Resident R1 had an unwitnessed fall on 12/12/25. During an interview on 2/11/26, at 12:27 p.m. the Nursing Home Administrator confirmed that the facility failed to provide care and services needed for residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of three residents (Resident R1). 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(5) Nursing services.

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