STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026
NAME OF PROVIDER OR SUPPLIER Hillcrest Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, it was determined that the facility failed to properly maintain kitchen equipment in a sanitary condition creating the potential for cross contamination in the main kitchen of the facility, and failed to properly monitor refrigerator temperatures for two of two nursing units (East and Northwest) which created the potential for food borne illness.Findings include: During an observation with Food Services Director (FSD) Employee E12 in the Main Kitchen on 4/13/26, at 10:20 a.m. revealed that the cold air condenser unit, (2) fan covers, and the area immediately surrounding in the main walk-in cooler had a build-up of dust, grime, and dark colored debris. During an interview on 4/13/26, at 10:21 a.m. the FSD Employee E12 confirmed that the facility failed to properly maintain kitchen equipment in a sanitary condition in the Main kitchen walk-in cooler. During an observation on 4/16/26, at 9:10 a.m. with FSD Employee E12 revealed the East Nursing Unit refrigerator was found with an incomplete temperature log for April 2026. During an observation on 4/16/26, at 9:14 a.m. with FSD Employee E12 revealed the Northwest Nursing Unit refrigerator was found without a temperature log for April 2026. During an interview on 4/16/26, at 9:15 a.m. FSD Employee E12 confirmed that the facility failed to properly monitor refrigerator temperatures for two of two nursing units (East and Northwest) which created the potential for food borne illness. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1) Management.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview it was determined that the facility failed to make certain resident medication regimens were free from potentially unnecessary psychotropic (substances that act on the brain to alter cognition, perception, and mood) medications without adequate indications for use for three of six residents (Resident R2, R19, and R90). Findings include: Review of facility policy Antipsychotic Medication Use, dated 1/15/26, indicated: Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The attending physician and other staff will gather and document information to clarify a residents behavior, mood, function, medical condition specific symptoms and risks to the residents and others. Residents will not receive PRN doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record. PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication and documented the rationale for continued use. The duration of the PRN order will be indicated in the order. Review of Resident R2 admission record indicated he was admitted on [DATE]. Review of Resident R2 admission record indicated diagnosis of anxiety disorder (group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), and altered mental status (is a change in mental in mental function. It stems from certain illnesses, disorders and injuries affecting your brain). Review of Resident R2's clinical record MAR for April 2026 (medication administration record - record used to document medications given to a resident) indicated: Vistaril (is used to control anxiety and tension caused by nervous and emotional conditions) oral capsule 25 mg (hydroxzyine pamoate) give 1 capsule by mouth every 6 hours as needed for anxiety/agitation start date 4/1/26: review of the MAR indicated medication was given: 4/4/26: 2106 (9:06 p.m.). 4/9/26: 1458 (2:58 p.m.) 4/10/26: 1456 (2:56 p.m.) 4/12/26: twice at 900 and 2209 (9:00 a.m. and 10:09 p.m.) 4/15/26: 1653 (4:53 p.m.) And Zyprexa oral tablet (olanzapine) (is an antipsychotic that can treat schizophrenia and bipolar disorder. It balances the levels of dopamine and serotonin in your brain) give 2.5mg by mouth every 6 hours as (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needed for agitation: review of the MAR indicated medication was given: 4/13/26: 1318 (1:18 p.m.) 4/14/26: 1013 (10:13 a.m.) 4/15/26: 1653 (4:53 p.m.) Review of the MAR and clinical progress notes failed to include what non-pharmacological interventions were provided prior to giving the prn medications. During an interview on 4/16/26, at 2:42 p.m. DON (Director of Nursing) confirmed that the facility failed to provide non-pharmacological interventions were provided prior to giving the prn medications. Review of Resident R19's admission record indicated she was admitted [DATE]. Review of Resident R19's Minimum Data Set (MDS- periodic assessment of care needs) dated 3/15/26, indicated diagnoses of pneumonia (infection that inflames the air sacs in one or both lungs), dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities), and anxiety disorder. Review of Section N: Medications revealed Resident R19 received antianxiety medications in the seven days prior to the assessment. Review of Resident R19's physician order dated 3/19/26, indicated Ativan (is used to treat anxiety disorder, insomnia, and other conditions. It works by enhancing the activity of certain neurotransmitters in the brain, leading to relaxation and reduced anxiety) oral tablet 0.5 mg (milligram) give 1 tablet by mouth every six hours as needed for anxiety. Review of Resident R19's physician order failed to include a 14 day stop date and there was no documented rationale by the physician for the medication to extend past 14 days for Resident R19s Ativan. Review of Resident R19's clinical record MAR for April 2026 (medication administration record - record used to document medications given to a resident) indicated: Ativan oral tablet 0.5 mg (Lorazepam) Give 1 tablet by mouth every 6 hours as needed for anxiety start date: 3/19/26. Review of the April 2026 MAR indicated medication was given: 4/1/26: three times a day at 845, 1510, and 1949 (8:45 a.m., 3:10 p.m., and 7:49 p.m.) 4/2/26: two times a day at 1322, 1933 (1:22 p.m. and 7:33 p.m.) 4/3/26: three times a day at 908, 1515, and 2128 (9:08 a.m., 3:15 p.m. and 9:28 p.m.) 4/4/26: once a day at 1013 (10:13 a.m.) 4/5/26: once a day at 2200 (10:00 p.m.) 4/6/26: two times a day at 0815 and 1615 (8:15 a.m. and 4:15 p.m.) (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/7/26: two times a day at 0940 and 1918 (9:40 a.m. and 7:18 p.m.) 4/8/26: three times a day at 638, 1328, 2000 (6:38 a.m., 1:28 p.m. and 8:00 p.m.) 4/9/26: two times a day at 908 and 2055 (9:08 a.m. and 8:55 p.m.) 4/10/26: two times a day at 1332 and 1940 (1:32 p.m. and 7:40 p.m.) 4/11/26: once a day at 1344 (1:44 p.m.) 4/12/26: three times a day at 836, 1441, and 2049 (8:36 a.m., 2:41 p.m. and 8:49 p.m.) 4/13/26: two times a day at 753 and 1910 (7:53 a.m. and 7:10 p.m.) 4/14/26: three times a day at 545, 1216, and 1847 (5:45 a.m., 12:16 p.m. and 6:47 p.m.) 4/15/26: three times a day at 807, 1410,and 2015 (8:07 a.m., 2:10 p.m. and 8:15 p.m.) 4/16/26: once a day at 708 (7:08 a.m.) Review of the MAR and clinical progress notes failed to include what non-pharmacological interventions were provided prior to giving the prn medications. During an interview on 4/15/26, at 1:48 p.m., the DON confirmed that the facility failed to make certain resident medication regimens were free from potentially unnecessary psychotropic medications without adequate indications for use for Resident R19. Review of Resident R60's admission record indicated she was admitted [DATE]. Review of Resident R60's MDS assessment dated [DATE], indicated diagnoses of lung cancer, respiratory failure, and high blood pressure. Review of Section N: Medications revealed Resident R60 received antianxiety medications in the seven days prior to the assessment. Review of Resident R60's physician order dated 3/11/26, indicated Ativan oral tablet 1.0 mg (Lorazepam) give 1 tablet by mouth every four hours as needed for agitation/restlessness. Review of Resident R60's physician order failed to include a 14 day stop date and there was no documented rationale by the physician for the medication to extend past 14 days for Resident R60's Ativan. Review of Resident R60's clinical record MAR for April 2026 (medication administration record - record used to document medications given to a resident) indicated: Ativan oral tablet 1.0 mg (Lorazepam) Give 1 tablet by mouth every 6 hours as needed for anxiety start date: 3/11/26. Review of the April 2026 MAR indicated medication was given: 4/1/26: two times a day at 903 and 2021 (9:03 a.m. and 8:21 p.m.) 4/2/26: two times a day at 1225 and 2050 (12:25 p.m. and 8:50 p.m.) (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/5/26: once a day at 804 (8:04 a.m.) 4/6/26: once a day at 2035 (8:35 p.m.) Review of the MAR and clinical progress notes failed to include what non-pharmacological interventions were provided prior to giving the prn medications. During an interview on 4/16/26, at 10:46 a.m., the DON confirmed that the facility failed to make certain resident medication regimens were free from potentially unnecessary psychotropic medications without adequate indications for use for Resident R60. 28 Pa Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.5(f) Medical records. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide enough food/fluids to maintain a resident's health.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on a review of the facility policy, clinical record reviews and staff interviews, it was determined that the facility failed to assess the nutritional status as required, failed to properly monitor weight and nutrition status by failing to obtain weights or act upon weight changes for four of six residents (Resident R5, R30, R40, and R50), and failed to update an individualized care plan to address the resident's specific nutritional concerns for two of six resident (Resident R40 and R50) records reviewed.

Findings include:

Review of the facility policy Nutritional assessment dated [DATE], previously dated 2/20/25, indicated that as part of the comprehensive assessment, a nutrition assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident. The dietitian will conduct a nutritional assessment for each resident upon admission and as indicated by a change in condition that places the resident at risk for impaired nutrition. As part of the comprehensive, the nutritional assessment will be a systemic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. Once current condition and risk factors for impaired nutrition are assessed and analyzed, individual care plans will be developed that address or minimize to the extent possible the resident's risks for nutritional complications, Such interventions will be developed within the context of the resident's prognosis and personal preferences.

Review of facility policy Weight Assessment and Interventions dated 1/15/26, previously dated 2/20/25, indicated that multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. The nursing staff will measure resident weights on admission and weekly for four weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. Weights will be recorded in the resident's electronic medical record. Any weight change of 5% or more since the last weight assessment will be addressed by the Dietitian. The threshold for significant unplanned and undesired weight loss will be based on the following criteria:

1 month - 5% weight loss is significant; greater than 5% is severe.

3 months - 7.5% weight loss is significant; greater than 7.5% is severe.

6 months - 10% weight loss is significant; greater than 10% is severe.

Review of the clinical record revealed Resident R5 was admitted to the facility on [DATE].

Review of Resident R5's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/18/26, indicated diagnoses of high blood pressure, anxiety, and history of falling.

Review of Resident R5's weight record failed to reveal any documented weights for June 2025 or July 2025.

During an interview on 4/17/26, at 10:25 a.m. the Director of Nursing (DON) confirmed that the facility failed to properly monitor weight and status by failing to obtain and document weights for Resident
(continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5. Review of Resident R30's admission record indicated she was admitted to the facility 5/11/25. Review of Resident R30's MDS assessment dated [DATE], included diagnoses of heart failure, adult failure to thrive, and paroxysmal atrial fibrillation (irregular heart rhythm). Section K0300 was coded a 2, which indicated that Resident R30 had a weight loss of 5% or more in the last month or weight loss of 10% or greater in the last six months. Review of Resident R30's Nutrition Evaluation dated 4/2/26, indicated that current weight from 3/5/26, was 125# (pounds), weight loss noted in 3 months, and significant weight loss 11.5% x 180 days (6 months). Documentation failed to indicate specific dates and weights referenced in evaluation. Review of Weight Summary for Resident R30 indicated the following weights: 3/5/26 - 125# 2/13/25 - 126# 2/4/25 - 124.8# 9/2/25 - 141.2# Documentation failed to include weights for October 2025, November 2025, December 2025, and January 2025, indicating inaccurate documentation of weight loss in 3 months due to weight not being obtained in December 2025, as noted in 4/2/26 Nutrition Evaluation. During an interview of 4/17/26, at 11:15 a.m., the DON confirmed that the facility failed to properly obtain weights for Resident R30 therefor documentation of nutritional status was inaccurate. Review of Resident R30's MDS assessment dated [DATE], Section K0200B Weight (in pounds) revealed a - (dash - standard no information code), however rationale for use of standard no information code was not documented. Further review of clinical record failed to reveal documentation of Resident R30's nutritional status relevant to MDS assessment dated [DATE]. During an interview on 4/17/26, at 12:18 p.m., Licensed Practical Nurse Assessment Coordinator (LPNAC) Employee E3 confirmed that a - was coded on Resident R30's MDS dated [DATE], Section K0200B and further confirmed that the clinical record failed to contain a clinical nutritional assessment explaining rationale for MDS documentation or current nutritional status. Review of Resident R40's admission record indicated she was admitted to the facility 10/28/25. Review of Resident R40's MDS assessment dated [DATE], included diagnoses of rhabdomyolysis (condition characterized by the rapid breakdown of skeletal muscles), morbid obesity, and respiratory failure. Review of Section Z - Assessment Administration revealed that LPNAC Employee E3 completed Section K on 1/15/26. Review of the clinical record for Resident R40 failed to reveal clinical nutrition documentation (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed by a Registered Dietitian for MDS assessment dated [DATE]. Review of Weight Summary on for Resident R40 indicated the following weights: 3/5/26 - 238# 2/13/26 - 241.6# -- entry was errored out by the DON 12/2/25 - 336# 12/1/25 - 336# 11/10/25 - 336.3# 10/29/25 - 337# Documentation failed to include weights for the week of 11/2/25, week of 11/16/25, monthly weight for January 2026, and monthly weight for February 2026. As of review on 4/17/26, Resident R40's monthly weight had not been obtained. Review of clinical nutrition note dated 2/19/26, by Registered Dietitian Employee E13 revealed weight obtained 2/13 is a suspected entry error. Recommendation: obtain reweight. Review of clinical nutrition note dated 3/12/26, by RD Employee E13 revealed weight 3/5 likely an entry error. Recommendation: obtain reweight. RD will continue to monitor, and follow-up as needed. During an interview of 4/17/26, at 11:15 a.m., the DON confirmed that the facility failed to properly obtain reweights as requested and monthly weights for Resident R40. Review of Nutrition Evaluation dated 4/14/26, by RD Employee E13, identified current body weight as 238# on 3/5/26, stating weight noted to be stable at present time. Further review of Nutritional Evaluation failed to identify, provide rationale, or recommend interventions for significant weight loss of 98# from 12/2/25, weight, until current weight per evaluation of 238#. Review of Resident R40's current plan of care, updated 2/3/26, failed to indicate any nutritional concerns related to significant weight loss or interventions to prevent significant weight loss. During interview on 4/17/26, at 12:23 p.m., LPNAC Employee E3 confirmed that Resident R30's clinical record failed to provide clinical nutrition documentation by the RD for MDS assessment dated [DATE], and failed to have significant weight loss addressed accurately by the RD; LPNAC Employee E3 also confirmed that Resident R30's care plan failed to address current nutritional status identifying significant weight loss of 98# with goals and interventions. Review of Resident R50's admission record indicated he was admitted to the facility 4/24/24. Review of Resident R50's MDS assessment dated [DATE], included diagnoses of heart failure, dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities), and high blood pressure. Section K0300 was coded a 2, which indicated that Resident R50 had a weight loss of 5% or more in the last month or (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	weight loss of 10% or greater in the last six months. Review of Section Z - Assessment Administration revealed that LPNAC Employee E3 completed Section K on 3/8/26, 1/1/26, and 12/26/25 MDS assessments. Review of physician order dated 1/1/26, indicated 2.0 (calorie) nutritional supplement two times a day for nutrition support/increased nutrient needs/weight maintenance; 120 mls (milliliters) 2x/day with AM/PM med passes. Review of Nutrition Evaluation dated 3/10/26, by RD Employee E13 indicated current weight of Resident R50 to be 144# on 2/4/26; further noted that no weight obtained x 30 days, and significant weight loss 8.8% x 90 days. Nutrition Evaluation failed to identify date and weight of referenced significant loss. Review of Weight Summary for Resident R50 indicated the following weights: 4/13/26 - 153.4# 3/15/26 - 158.2# (significant weight gain of 9.9% x 30 days) 2/4/26 - 144# (significant weight loss of 8.8% x 90 days) 12/6/25 - 148# 12/5/25 - 148.2# 12/4/25 - 149.8# 11/11/25 - 157.8# 10/3/25 - 157.3# 9/28/25 - 155.8# 9/1/25 - 157.8# 5/3/25 - 155.4# Documentation failed to include a weight for January 2026. During an interview of 4/17/26, at 11:15 a.m., the DON confirmed that the facility failed to properly obtain a monthly weight for Resident R50 for January 2026. Review of clinical nutrition note dated 2/6/26, by RD Employee E13 identified significant weight loss of 8.8% by Resident R50 x 90 days; review of clinical nutrition note dated 3/24/26, identified significant weight gain of 9.9% x 30 days, reweight pending. Both clinical nutrition notes failed to identify date and weight of referenced significant weight change. Review of clinical nutrition documentation failed to reveal nutrition notes or evaluations from 9/23/25, until 2/6/26, indicating that Resident R50's MDS's dated 12/26/25, and 1/14/26, failed to (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have a RD assess his nutritional status. Review of Resident R50 current plan of care, updated 4/9/26, failed to identify significant weight changes as a nutrition focus, and failed to include current 2.0 nutritional supplement as an intervention. During an interview on 4/17/26, at 12:28 p.m., LPNAC Employee E3 confirmed that RD Employee E13 failed to provide referenced dates for time frames of significant weight change documentation, failed to maintain accurate care plan, and failed to assess Resident R50's nutritional status from 9/23/25, through 2/6/26. During an interview on 4/17/26, at 2:45 p.m., the Nursing Home Administrator and DON confirmed that the facility failed to assess the nutritional status as required, failed to properly monitor weight and nutrition status by failing to obtain weights or act upon weight changes for four of six residents (Resident R5, R30, R40, and R50), and failed to update an individualized care plan to address the resident's specific nutritional concerns for two of six resident (Resident R40 and R50) records reviewed. 28 Pa. Code: 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for five of six residents (Residents R1, R4, R47, R54, and R61).Findings include: Review of the facility policy Administering Medications through a Small Volume (handheld) Nebulizer last reviewed 1/15/26, indicated the purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. When treatment is completed rinse and disinfect the nebulizer equipment. When equipment is completely dry, store it in a plastic bag with the resident's name and date on it. Review of the facility policy CPAP (continuous positive airway pressure)/BiPAP (bilevel positive pressure) Support last reviewed 1/15/26, indicated to improve oxygenation in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease. To promote resident comfort and safety. Review of facility policy Oxygen Administration dated 1/15/26, indicated staff are to verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident. Review of the clinical record revealed 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 4/6/26, indicated diagnoses of high blood pressure, respiratory failure (a condition where the lungs cannot get enough oxygen into the blood), and obstructive sleep apnea (OSA - disorder that causes breathing to repeatedly stop and start during sleep). Review of a physician order dated 12/6/25, indicated BiPAP settings 15/8 bleed in 3 liters of oxygen every night shift for OSA. During an observation on 4/13/26, at 10:24 a.m. Resident R1's BiPAP machine was observed on the resident's bedside table, the mask was laying on the table, not stored in a bag while not in use. During an interview on 4/13/26, at 10:37 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed Resident R1's BiPAP mask was not stored in a plastic bag while not in use and that the facility failed to provide appropriate respiratory care. Review of the clinical record revealed Resident R4 was originally admitted to the facility 10/30/23, recently readmitted [DATE]. Review of Resident R4's MDS dated [DATE], indicated diagnoses of urinary tract infection, respiratory failure, and diabetes mellitus (chronic condition that occurs when the body cannot properly use blood sugar (glucose), leading to high blood sugar levels). Review of a physician order dated 3/23/26, indicated Oxygen at: 4 liters per minute via nasal cannula (medical device that delivers supplemental oxygen directly into the nostrils) as needed for SOB (shortness of breath). (continued on next page)

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Hillcrest Rehabilitation & Healthcare Center	100 Little Drive Lower Burrell, PA 15068

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R4's current plan of care updated 2/12/26, indicated oxygen per physician orders. During an observation on 4/13/25, at 11:20 a.m., Resident R4's nasal cannula was found lying on the floor next to his bed, between the wall and his concentrator, not stored in a bag while not in use. During an interview on 4/13/26, at 11:24 a.m., Registered Nurse (RN) Employee E14 confirmed that Resident R4's nasal cannula was lying on the floor, between the wall and his concentrator, not stored in a bag while not in use. Review of Resident R47's clinical record indicated an admission date of 6/15/24. Review of R47's MDS dated [DATE], indicated the diagnosis of hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD- restricts breathing), and hyperlipidemia (high fats in the blood). Review of Resident R47's physician orders dated 4/5/26, indicated Ipratropium-Albuterol 0.5-2.5 milligram (MG)/3 milliliter (ML) Solution administer one ampule via nebulizer every four hours as needed for wheezing. During an observation completed on 4/13/26, at 10:58 a.m. indicated a handheld nebulizer sitting on top of Resident 47's nightstand, not stored in a bag as required. During an interview completed on 4/13/26, at 11:01 a.m. LPN Employee E9 confirmed the nebulizer was on the nightstand not stored in as bag as required and stated, it should be. Review of Resident R54's clinical record indicated an admission date of 3/30/22. Review of Resident R54's MDS dated [DATE], indicated the diagnoses of COPD, diabetes (high sugar in the blood) and heart failure (the heart doesn't pump the way it should). Review of Resident R54's physician orders dated 3/4/26, indicated Noninvasive ventilation BiPap on every night shift keep oxygen saturation 90% and above every night shift for COPD During an observation completed on 4/13/26, at 10:44 a.m. indicated a BiPap mask on the nightstand, not stored in a bag as required. During an interview completed on 4/13/26, at 11:02 a.m. LPN Employee E9 confirmed the BiPap mask was not stored in a bag as required and confirmed that the facility failed to provide appropriate respiratory care. Review of the clinical record revealed Resident R61 was admitted to the facility on [DATE]. Review of Resident R61's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and anxiety. During an observation on 4/13/26, at 10:08 a.m. Resident R61 was observed receiving two liters of oxygen via nasal cannula. Review of Resident R61's clinical record failed to reveal a physician order for oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R61's comprehensive care plan failed to reveal goals and interventions related to the resident's oxygen therapy. During an interview on 4/15/26, at 12:56 p.m. LPN Employee E1 confirmed Resident R61 did not have a physician order for oxygen therapy and stated, Usually residents have an order for oxygen. During an interview on 4/16/26, at 1:59 p.m. Licensed Practical Nurse Assessment Coordinator Employee E3 confirmed Resident R61 did not have a physician order for oxygen or a care plan developed for oxygen therapy and that the facility failed to provide appropriate respiratory care. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly store medications in two of three medication carts (North Hall Medication Cart and [NAME] Hall Medication Cart) and one of two medication storage rooms (East Medication Room) and failed to properly secure a medication cart while not in use for one of three medication carts (East Hall Medication Cart). Findings include: Review of the facility policy Administering Medications last reviewed 1/15/26, indicated when opening a multi-dose container, the date opened is recorded on the container. During administration of medications, the medication cart is kept closed and locked. Review of the facility policy Storage of Medications last reviewed 1/15/26, indicated medications and biologicals are stored safely, securely, and properly, Medication storage areas are kept clean, well-lit and free of clutter and extreme temperatures. Outdated, contaminated, or deteriorated medications and those that are cracked, soiled, or without secure closures are immediately removed from sock and disposed of. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. During an observation completed on 4/14/26, at 10:40 a.m. the [NAME] Hall Medication Cart contained: 1 bottle of Lactulose opened and failed to be labeled with a date as required During an interview completed on 4/14/26, at 10:46 a.m. Licensed Practical Nurse (LPN) Employee E9 confirmed the bottle of Lactulose was opened and failed to be labeled with a date as required and that the facility failed to properly store medications. During an observation completed on 4/14/26, 10:46 a.m. the North Hall medication Cart contained the following: - 1 opened bottle of normal saline solution opened and labeled 4/11/26. - 1 tube mupirocin cream opened and not labeled with a date as required. - 1 bottle plain packing strip opened and not labeled with a date as required. - 1 tube manuka honey opened and not labeled with a date as required. - 1 albuterol inhaler opened and not labeled with a date as required. - 2 deep spray nasal saline opened and not labeled with a date as required. - 1 bottle of tums opened and not labeled with a date as required. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 1 small package of ritz bit crackers. During an interview completed on 4/14/26, at 11:04 a.m. LPN Employee E10 confirmed the above observations and stated, the normal saline should be good for 24 hours after opening and the crackers are given to residents during the medication pass and that the facility failed to properly store medications. During an observation completed on 4/14/26, at 11:09 a.m. the East Medication Room contained the following: 1 bottle tube green pain relief gel opened and not labeled with a date as required. 1 clear glass vase in the top cupboard next to refrigerator. 1 ceramic snowman sitting on top on top of refrigerator. 1 hat decorated for Christmas. 1 Christmas stocking. A radio 2 black coffee cups The medication room refrigerator contained: 1 vial Tubersol opened and not labeled with a date as required. 1 bottle of liquid gabapentin opened and not labeled with a date as required. During an interview completed 4/14/26, at 11:17 a.m. LPN Employee E1 confirmed the above observations and that the facility failed to properly store medications. During an observation on 4/15/26, at 8:16 a.m. the East Hall Medication Cart was at the nurse's station unlocked and unattended. During an interview on 4/15/26, at 8:18 a.m. LPN Employee E1 confirmed the above observation and that the facility failed to properly secure a medication cart while not in use. 28 Pa. Code: 201(a) Responsibility of licensee. 28 Pa. Code: 211.9(a)(1) Pharmacy services. 28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, resident clinical records, and staff interview, it was determined the facility failed to obtain a diagnosis for hospice services for one of four residents (Resident R60) and failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end of life care for three of four residents (Residents R9, R60, and R61). Finding include: Review of facility policy Hospice Program dated 1/15/26, indicated in general, it is the responsibility of the facility to meet the resident's personal and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. This includes communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day. The coordinated care plan shall be revised and updated as necessary to reflect the resident's current status including diagnosis. Review of the clinical record revealed Resident R9 was admitted to the facility on [DATE]. Review of Resident R9 MDS (minimum data set - a periodic assessment of resident needs) dated 2/24/26, indicated diagnosis of non-traumatic brain dysfunction (neurological consequences of an inquired brain injury of traumatic or non-traumatic origin) and Alzheimer's disease (brain condition that slowly damages your memory, thinking, learning and organizing skills). Review of Section O, Question O0110K1 indicated the resident received hospice care while in the facility. Review of Resident R9 physician orders indicated diagnosis of senile degeneration of brain. Review of Resident R9 comprehensive care plan failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to include contact information for the hospice agency and how to access the hospice's 24 hour on-call system. During an interview on 4/16/26, at 2:42 p.m. the Director of Nursing (DON) confirmed that the facility failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for Resident R9. Review of the clinical record revealed Resident R60 was admitted to the facility on [DATE]. Review of Resident R60's MDS dated [DATE], indicated diagnoses of lung cancer, respiratory failure, and high blood pressure. Review of Section O, Question O0110K1 indicated the resident received hospice care while in the facility. Review of a physician order dated 2/4/26, indicated to admit to hospice. Physician order failed to include diagnosis for providing hospice services Review of Resident R60's current comprehensive care plan failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to include diagnosis for providing services, contact information for the hospice agency and how to access the hospice's 24 hour on-call (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	system. During an interview on 4/16/26, at 2:15 p.m. Licensed Practice Nurse Assessment Coordinator (LPNAC) Employee E3 confirmed that the facility failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for Resident R60. Review of the clinical record revealed Resident R61 was admitted to the facility on [DATE]. Review of Resident R61's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and anxiety. Review of Section O, Question O0110K1 indicated the resident received hospice care while in the facility. Review of a physician order dated 1/28/26, indicated to admit resident to hospice services with a diagnosis of heart failure. Review of Resident R61's current comprehensive care plan failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to include contact information for the hospice agency and how to access the hospice's 24 hour on-call system. During an interview on 4/16/26, at 2:35 p.m. LPNAC Employee E3 confirmed that the facility failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for Resident R61. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(3)(5) Nursing services.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that a COVID-19 vaccination was offered to five of five residents (Residents R6, R8, R34, R37, and R65).Findings include: Review of facility policy SARS-CoV-2 Management dated 1/15/26, indicated the facility will encourage everyone to remain up to date with all recommended COVID-19 vaccine doses. Review of the Centers for Disease Control (CDC) document Staying Up to Date with COVID-19 Vaccines dated 11/19/25, indicated the CDC recommends a 2025-2026 COVID-19 vaccine for people ages 6 months and older based on individual-based decision-making. The COVID-19 vaccine helps protect you from severe illness, hospitalization, and death. It is especially important to get your 2025-2026 COVID-19 vaccine if you are ages 65 and older, are at high risk for severe COVID-19, or have never received a COVID-19 vaccine. Review of the clinical record revealed Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/31/26, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and anxiety. Question O0350 was coded no for Resident's COVID-19 vaccination is up to date. Review of Resident R6's clinical record indicated the resident was last offered and refused a COVID-19 vaccination on 11/6/23. Review of Resident R6's clinical record failed to include documentation that the COVID-19 vaccination was offered and administered or declined since 11/6/23. Review of the clinical record revealed Resident R8 was admitted to the facility on [DATE]. Review of Resident R8's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia, and schizoaffective disorder (a mental disorder in which a person experiences a combination of schizophrenia and mood disorder symptoms). Question O0350 was coded no for Resident's COVID-19 vaccination is up to date. Review of Resident R8's clinical record indicated the resident was last offered and refused a COVID-19 vaccination on 11/16/23. Review of Resident R8's clinical record failed to include documentation that the COVID-19 vaccination was offered and administered or declined since 11/16/23. Review of the clinical record revealed Resident R34 was admitted to the facility on [DATE]. Review of Resident R34's MDS dated [DATE], indicated diagnoses of high blood pressure, Chronic Obstructive Pulmonary Disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Question O0350 was coded no for Resident's COVID-19 vaccination is up to date. Review of Resident R34's clinical record indicated the resident last received a COVID-19 vaccination on 8/13/22. Review of Resident R34's clinical record failed to include documentation that the COVID-19 vaccination was offered and administered or declined since 8/13/22. Review of the clinical record indicated Resident R37 was admitted to the facility on [DATE]. Review of Resident R37's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia, and shortness of breath. Question O0350 was coded no for Resident's COVID-19 vaccination is up to date. Review of Resident R37's clinical record indicated the resident was last offered and refused a COVID-19 vaccination on 11/6/23. Review of Resident R37's clinical record failed to include documentation that the COVID-19 vaccination was offered and administered or declined since 11/6/23. Review of the clinical record indicated Resident R65 was admitted to the facility on [DATE]. Review of Resident R65's MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety, and depression. Question O0350 was coded no for Resident's COVID-19 vaccination is up to date. Review of Resident R65's clinical record indicated the resident last received a COVID-19 vaccination on 11/16/23. Review of Resident R65's clinical record failed to include documentation that the COVID-19 vaccination was offered and administered or declined since 11/16/23. During an interview on 4/15/26, at 2:40 p.m. Infection Preventionist Employee E2 confirmed that the facility (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	failed to make certain that a COVID-19 vaccination was offered to five of five residents (Residents R6, R8, R34, R37, and R65). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.5(f) Medical records.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Effective Communication for five of five staff members (Nurse Aide (NA) Employee E4, NA Employee E5, Registered Nurse (RN) Employee E6, Licensed Practical Nurse (LPN) Employee E7, and NA Employee E8).Findings include: Review of facility policy In-Service Training Program, Nurse Aide dated 1/15/26, indicated all nurse aide personnel participate in regularly scheduled in-service training classes. Insofar as practical, notice of in-service training classes, their time, place, date, etc., are posted on the employee bulletin board at least seven (7) days prior to the scheduled class. All training classes attended by the employee are entered on the respective employee's Record of In-Service by the department supervisor or other person(s) as designated by the supervisor. Review of NA Employee E4's personnel file indicated a date of hire on 3/20/24. Review of NA Employee E4's personnel file did not include credible annual in-service training on Effective Communication from 1/1/25 through 12/31/25. Review of NA Employee E5's personnel file indicated a date of hire on 10/22/19. Review of NA Employee E5's personnel file did not include credible annual in-service training on Effective Communication from 1/1/25 through 12/31/25. Review of RN Employee E6's personnel file indicated a date of hire on 5/30/19. Review of RN Employee E6's personnel file did not include credible annual in-service training on Effective Communication from 1/1/25 through 12/31/25. Review of LPN Employee E7's personnel file indicated a date of hire on 10/19/15. Review of LPN Employee E7's personnel file did not include credible annual in-service training on Effective Communication from 1/1/25 through 12/31/25. Review of NA Employee E8's personnel file indicated a date of hire on 3/9/81. Review of NA Employee E8's personnel file did not include credible annual in-service training on Effective Communication from 1/1/25 through 12/31/25. During an interview on 4/16/26, at 2:15 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on Effective Communication for five of five staff members (NA Employee E4, NA Employee E5, RN Employee E6, LPN Employee E7, and NA Employee E8). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a)(d) Staff development.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Resident Rights for five of five staff members (Nurse Aide (NA) Employee E4, NA Employee E5, Registered Nurse (RN) Employee E6, Licensed Practical Nurse (LPN) Employee E7, and NA Employee E8).Findings include: Review of facility policy In-Service Training Program, Nurse Aide dated 1/15/26, indicated all nurse aide personnel participate in regularly scheduled in-service training classes. Insofar as practical, notice of in-service training classes, their time, place, date, etc., are posted on the employee bulletin board at least seven (7) days prior to the scheduled class. All training classes attended by the employee are entered on the respective employee's Record of In-Service by the department supervisor or other person(s) as designated by the supervisor. Review of NA Employee E4's personnel file indicated a date of hire on 3/20/24. Review of NA Employee E4's personnel file did not include credible annual in-service training on Resident Rights from 1/1/25 through 12/31/25. Review of NA Employee E5's personnel file indicated a date of hire on 10/22/19. Review of NA Employee E5's personnel file did not include credible annual in-service training on Resident Rights from 1/1/25 through 12/31/25. Review of RN Employee E6's personnel file indicated a date of hire on 5/30/19. Review of RN Employee E6's personnel file did not include credible annual in-service training on Resident Rights from 1/1/25 through 12/31/25. Review of LPN Employee E7's personnel file indicated a date of hire on 10/19/15. Review of LPN Employee E7's personnel file did not include credible annual in-service training on Resident Rights from 1/1/25 through 12/31/25. Review of NA Employee E8's personnel file indicated a date of hire on 3/9/81. Review of NA Employee E8's personnel file did not include credible annual in-service training on Resident Rights from 1/1/25 through 12/31/25. During an interview on 4/16/26, at 2:15 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on Resident Rights for five of five staff members (NA Employee E4, NA Employee E5, RN Employee E6, LPN Employee E7, and NA Employee E8). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a)(d) Staff development.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Abuse, Neglect, and Exploitation for five of five staff members (Nurse Aide (NA) Employee E4, NA Employee E5, Registered Nurse (RN) Employee E6, Licensed Practical Nurse (LPN) Employee E7, and NA Employee E8).Findings include: Review of facility policy In-Service Training Program, Nurse Aide dated 1/15/26, indicated all nurse aide personnel participate in regularly scheduled in-service training classes. Insofar as practical, notice of in-service training classes, their time, place, date, etc., are posted on the employee bulletin board at least seven (7) days prior to the scheduled class. All training classes attended by the employee are entered on the respective employee's Record of In-Service by the department supervisor or other person(s) as designated by the supervisor. Review of NA Employee E4's personnel file indicated a date of hire on 3/20/24. Review of NA Employee E4's personnel file did not include credible annual in-service training on Abuse, Neglect, and Exploitation from 1/1/25 through 12/31/25. Review of NA Employee E5's personnel file indicated a date of hire on 10/22/19. Review of NA Employee E5's personnel file did not include credible annual in-service training on Abuse, Neglect, and Exploitation from 1/1/25 through 12/31/25. Review of RN Employee E6's personnel file indicated a date of hire on 5/30/19. Review of RN Employee E6's personnel file did not include credible annual in-service training on Abuse, Neglect, and Exploitation from 1/1/25 through 12/31/25. Review of LPN Employee E7's personnel file indicated a date of hire on 10/19/15. Review of LPN Employee E7's personnel file did not include credible annual in-service training on Abuse, Neglect, and Exploitation from 1/1/25 through 12/31/25. Review of NA Employee E8's personnel file indicated a date of hire on 3/9/81. Review of NA Employee E8's personnel file did not include credible annual in-service training on Abuse, Neglect, and Exploitation from 1/1/25 through 12/31/25. During an interview on 4/16/26, at 2:15 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on Abuse, Neglect, and Exploitation for five of five staff members (NA Employee E4, NA Employee E5, RN Employee E6, LPN Employee E7, and NA Employee E8). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a)(d) Staff development.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026
NAME OF PROVIDER OR SUPPLIER: Hillcrest Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 Little Drive, Lower Burrell, PA 15068	

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Quality Assurance and Performance Improvement (QAPI) for five of five staff members (Nurse Aide (NA) Employee E4, NA Employee E5, Registered Nurse (RN) Employee E6, Licensed Practical Nurse (LPN) Employee E7, and NA Employee E8).Findings include: Review of facility policy In-Service Training Program, Nurse Aide dated 1/15/26, indicated all nurse aide personnel participate in regularly scheduled in-service training classes. Insofar as practical, notice of in-service training classes, their time, place, date, etc., are posted on the employee bulletin board at least seven (7) days prior to the scheduled class. All training classes attended by the employee are entered on the respective employee's Record of In-Service by the department supervisor or other person(s) as designated by the supervisor. Review of NA Employee E4's personnel file indicated a date of hire on 3/20/24. Review of NA Employee E4's personnel file did not include credible annual in-service training on QAPI from 1/1/25 through 12/31/25. Review of NA Employee E5's personnel file indicated a date of hire on 10/22/19. Review of NA Employee E5's personnel file did not include credible annual in-service training on QAPI from 1/1/25 through 12/31/25. Review of RN Employee E6's personnel file indicated a date of hire on 5/30/19. Review of RN Employee E6's personnel file did not include credible annual in-service training on QAPI from 1/1/25 through 12/31/25. Review of LPN Employee E7's personnel file indicated a date of hire on 10/19/15. Review of LPN Employee E7's personnel file did not include credible annual in-service training on QAPI from 1/1/25 through 12/31/25. Review of NA Employee E8's personnel file indicated a date of hire on 3/9/81. Review of NA Employee E8's personnel file did not include credible annual in-service training on QAPI from 1/1/25 through 12/31/25. During an interview on 4/16/26, at 2:15 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on QAPI for five of five staff members (NA Employee E4, NA Employee E5, RN Employee E6, LPN Employee E7, and NA Employee E8). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a)(d) Staff development.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Infection Control for five of five staff members (Nurse Aide (NA) Employee E4, NA Employee E5, Registered Nurse (RN) Employee E6, Licensed Practical Nurse (LPN) Employee E7, and NA Employee E8).Findings include: Review of facility policy In-Service Training Program, Nurse Aide dated 1/15/26, indicated all nurse aide personnel participate in regularly scheduled in-service training classes. Insofar as practical, notice of in-service training classes, their time, place, date, etc., are posted on the employee bulletin board at least seven (7) days prior to the scheduled class. All training classes attended by the employee are entered on the respective employee's Record of In-Service by the department supervisor or other person(s) as designated by the supervisor. Review of NA Employee E4's personnel file indicated a date of hire on 3/20/24. Review of NA Employee E4's personnel file did not include credible annual in-service training on Infection Control from 1/1/25 through 12/31/25. Review of NA Employee E5's personnel file indicated a date of hire on 10/22/19. Review of NA Employee E5's personnel file did not include credible annual in-service training on Infection Control from 1/1/25 through 12/31/25. Review of RN Employee E6's personnel file indicated a date of hire on 5/30/19. Review of RN Employee E6's personnel file did not include credible annual in-service training on Infection Control from 1/1/25 through 12/31/25. Review of LPN Employee E7's personnel file indicated a date of hire on 10/19/15. Review of LPN Employee E7's personnel file did not include credible annual in-service training on Infection Control from 1/1/25 through 12/31/25. Review of NA Employee E8's personnel file indicated a date of hire on 3/9/81. Review of NA Employee E8's personnel file did not include credible annual in-service training on Infection Control from 1/1/25 through 12/31/25. During an interview on 4/16/26, at 2:15 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on Infection Control for five of five staff members (NA Employee E4, NA Employee E5, RN Employee E6, LPN Employee E7, and NA Employee E8). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a)(d) Staff development.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Compliance and Ethics for five of five staff members (Nurse Aide (NA) Employee E4, NA Employee E5, Registered Nurse (RN) Employee E6, Licensed Practical Nurse (LPN) Employee E7, and NA Employee E8).Findings include: Review of facility policy In-Service Training Program, Nurse Aide dated 1/15/26, indicated all nurse aide personnel participate in regularly scheduled in-service training classes. Insofar as practical, notice of in-service training classes, their time, place, date, etc., are posted on the employee bulletin board at least seven (7) days prior to the scheduled class. All training classes attended by the employee are entered on the respective employee's Record of In-Service by the department supervisor or other person(s) as designated by the supervisor. Review of NA Employee E4's personnel file indicated a date of hire on 3/20/24. Review of NA Employee E4's personnel file did not include credible annual in-service training on Compliance and Ethics from 1/1/25 through 12/31/25. Review of NA Employee E5's personnel file indicated a date of hire on 10/22/19. Review of NA Employee E5's personnel file did not include credible annual in-service training on Compliance and Ethics from 1/1/25 through 12/31/25. Review of RN Employee E6's personnel file indicated a date of hire on 5/30/19. Review of RN Employee E6's personnel file did not include credible annual in-service training on Compliance and Ethics from 1/1/25 through 12/31/25. Review of LPN Employee E7's personnel file indicated a date of hire on 10/19/15. Review of LPN Employee E7's personnel file did not include credible annual in-service training on Compliance and Ethics from 1/1/25 through 12/31/25. Review of NA Employee E8's personnel file indicated a date of hire on 3/9/81. Review of NA Employee E8's personnel file did not include credible annual in-service training on Compliance and Ethics from 1/1/25 through 12/31/25. During an interview on 4/16/26, at 2:15 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on Compliance and Ethics for five of five staff members (NA Employee E4, NA Employee E5, RN Employee E6, LPN Employee E7, and NA Employee E8). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a)(d) Staff development.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Dementia Management and Resident Abuse Prevention for five of five staff members (Nurse Aide (NA) Employee E4, NA Employee E5, Registered Nurse (RN) Employee E6, Licensed Practical Nurse (LPN) Employee E7, and NA Employee E8) and failed to ensure that three of three sampled Nurse Aides received a minimum of 12 hours of in-service education per year (NA Employee E4, NA Employee E5, and NA Employee E8).Findings include: Review of facility policy In-Service Training Program, Nurse Aide dated 1/15/26, indicated all nurse aide personnel participate in regularly scheduled in-service training classes. Annual in-services are no less than 12 hours per employment year. Insofar as practical, notice of in-service training classes, their time, place, date, etc., are posted on the employee bulletin board at least seven (7) days prior to the scheduled class. All training classes attended by the employee are entered on the respective employee's Record of In-Service by the department supervisor or other person(s) as designated by the supervisor. Review of NA Employee E4's personnel file indicated a date of hire on 3/20/24. Review of NA Employee E4's personnel file did not include credible annual in-service training on Dementia Management and Resident Abuse Prevention from 1/1/25 through 12/31/25. Review of facility nurse aide training records did not include credible documentation that NA Employee E4 received 12 hours of in-service training from 1/1/25 through 12/31/25. Review of NA Employee E5's personnel file indicated a date of hire on 10/22/19. Review of NA Employee E5's personnel file did not include credible annual in-service training on Dementia Management and Resident Abuse Prevention from 1/1/25 through 12/31/25. Review of facility nurse aide training records did not include credible documentation that NA Employee E5 received 12 hours of in-service training from 1/1/25 through 12/31/25. Review of RN Employee E6's personnel file indicated a date of hire on 5/30/19. Review of RN Employee E6's personnel file did not include credible annual in-service training on Dementia Management and Resident Abuse Prevention from 1/1/25 through 12/31/25. Review of LPN Employee E7's personnel file indicated a date of hire on 10/19/15. Review of LPN Employee E7's personnel file did not include credible annual in-service training on Dementia Management and Resident Abuse Prevention from 1/1/25 through 12/31/25. Review of NA Employee E8's personnel file indicated a date of hire on 3/9/81. Review of NA Employee E8's personnel file did not include credible annual in-service training on Dementia Management and Resident Abuse Prevention from 1/1/25 through 12/31/25. Review of facility nurse aide training records did not include credible documentation that NA Employee E8 received 12 hours of in-service training from 1/1/25 through 12/31/25. During an interview on 4/16/26, at 2:15 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on Dementia Management and Resident Abuse Prevention for five of five staff members (NA Employee E4, NA Employee E5, RN Employee E6, LPN Employee E7, and NA Employee E8) and failed to ensure that three of three sampled Nurse Aides received a minimum of 12 hours of in-service education per year (NA Employee E4, NA Employee E5, and NA Employee E8) 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a)(d) Staff development.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Behavioral Health for five of five staff members (Nurse Aide (NA) Employee E4, NA Employee E5, Registered Nurse (RN) Employee E6, Licensed Practical Nurse (LPN) Employee E7, and NA Employee E8).Findings include: Review of facility policy In-Service Training Program, Nurse Aide dated 1/15/26, indicated all nurse aide personnel participate in regularly scheduled in-service training classes. Insofar as practical, notice of in-service training classes, their time, place, date, etc., are posted on the employee bulletin board at least seven (7) days prior to the scheduled class. All training classes attended by the employee are entered on the respective employee's Record of In-Service by the department supervisor or other person(s) as designated by the supervisor. Review of NA Employee E4's personnel file indicated a date of hire on 3/20/24. Review of NA Employee E4's personnel file did not include credible annual in-service training on Behavioral Health from 1/1/25 through 12/31/25. Review of NA Employee E5's personnel file indicated a date of hire on 10/22/19. Review of NA Employee E5's personnel file did not include credible annual in-service training on Behavioral Health from 1/1/25 through 12/31/25. Review of RN Employee E6's personnel file indicated a date of hire on 5/30/19. Review of RN Employee E6's personnel file did not include credible annual in-service training on Behavioral Health from 1/1/25 through 12/31/25. Review of LPN Employee E7's personnel file indicated a date of hire on 10/19/15. Review of LPN Employee E7's personnel file did not include credible annual in-service training on Behavioral Health from 1/1/25 through 12/31/25. Review of NA Employee E8's personnel file indicated a date of hire on 3/9/81. Review of NA Employee E8's personnel file did not include credible annual in-service training on Behavioral Health from 1/1/25 through 12/31/25. During an interview on 4/16/26, at 2:15 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on Behavioral Health for five of five staff members (NA Employee E4, NA Employee E5, RN Employee E6, LPN Employee E7, and NA Employee E8). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a)(d) Staff development.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to provide medications as ordered by the physician and ensure the physician was appropriately notified of missed medication doses for one of three residents reviewed (Resident R21).Findings include: Review of the facility Medication Ordering and Receiving Pharmacy last reviewed 1/15/26, indicated emergency pharmacy service is available on a 24-hour basis. Emergency needs for medications are met by using the facility's approved emergency supply or by special order from the provider pharmacy. The provider pharmacy supplies emergency medications including emergency drugs, antibiotics, controlled substances and products for infusion in limited quantities in sealed containers or automatic dispensing system (ADS). The ordered medication is obtained either from the emergency box or ADS, from the provider pharmacy or a back up pharmacy that is determined by the provider pharmacy. Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE], with the diagnosis of aftercare following joint repair surgery of left knee, hypertension (high blood pressure) and breast cancer. Review of Resident R21's nursing admission/readmission evaluation indicated admission to the facility on 4/2/26, at 4:54 p.m. Review of Resident R21's physician orders indicated:Cefadroxil Oral Capsule (used to treat bacterial infections by preventing bacteria from forming - preventing infection) 500 milligrams (MG) Give 1 capsule by mouth two times a day for status post-surgery related to aftercare following joint replacement surgery for seven days start date 4/2/26, at 9:00 p.m.Celecoxib Oral Capsule (anti-inflammatory) 200 MG Give 1 capsule by mouth two times a day for status post-surgery for 30 Days start date 4/2/26, at 9:00 p.m.Hydrochlorothiazide Oral Tablet (treats high blood pressure) 25 MG Give 1 tablet by mouth at bedtime for hypertension start date 4/2/26, at 9:00 p.m.Lysine Oral Tablet (wound healing) 500 MG give 1 tablet by mouth one time a day for nutrient deficiency start date 4/3/26 at 8:00 a.m. Review of Resident R21's April 2026, Medication Administration Record (MAR) revealed the following: Cefadroxil oral capsule scheduled 4/2/26, at 9:00 p.m. coded as 9 = other/see nursing notes Celecoxib oral capsule scheduled 4/2/26, at 9:00 p.m. coded as 9 = other/see nursing notes Hydrochlorothiazide oral tablet scheduled 4/2/26, at 9:00 pm coded as 9 = other/see nursing notes Lysine oral tablet scheduled for 4/3/26, at 8:00 a.m. and 4/5/26, at 8:00 a.m. coded as 9 = other/see nursing notes Review of Resident R21's order administration note dated 4/2/26, 4/3/26, and 4/5/26, indicated unavailable, awaiting from pharmacy. The nursing notes failed to ensure the physician was appropriately notified of the missed medication doses for Resident R21. During an interview completed on 4/16/26, at 12:10 p.m. upon reviewing Resident R21's MARS's, Licensed Practical Nurse (LPN) Employee E7 stated sometimes we will pull what we can from the emergency medication box and confirmed that the facility failed to provide medications as ordered by the physician and ensure the physician was appropriately notified of missed medication doses for one of three residents reviewed (Resident R21). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18 (b)(1) Management.28 Pa. Code: 211.10 (c)(d) Resident Care policies.28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the Resident Assessment Instrument (RAI) User's Manual, clinical record review, and staff interview, it was determined that the facility failed to ensure Minimum Data Set (MDS - a periodic assessment of care needs) assessments accurately reflected the resident's status for one of five residents (Residents R5).Findings include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2025, indicated the following instructions:O0110K1, Hospice care: code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. Review of the clinical record revealed Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety, and history of falling. Section O0110K1 (Hospice care) was coded yes, indicating that the resident received hospice care during the 14-day assessment period. Review of Resident R5's clinical record failed to reveal documentation that the resident was admitted to hospice services during the MDS dated [DATE], 14-day assessment period. During an interview on 4/16/26, at 2:35 p.m. Licensed Practical Nurse Assessment Coordinator Employee E3 confirmed Resident R5 was incorrectly coded as receiving hospice services on the MDS dated [DATE], and that the facility failed to ensure Resident R5's MDS assessment accurately reflected the resident's status. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 211.5(f) Medical records.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated and revised to reflect the resident's specific care needs for one of three residents (Residents R47).Findings include: Review of facility policy Care Plans, Comprehensive Person-Centered last reviewed 1/15/26, indicated assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Review of Resident R47's clinical record indicated an admission date of 6/15/24. Review of R47's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/10/26, indicated the diagnosis of hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD- restricts breathing), and hyperlipidemia (high fats in the blood). Review of Resident R47's physician order dated 12/24/25, indicated Azithromycin Oral Tablet 250 milligram. Give 1 tablet by mouth one time a day every Monday, Wednesday and Friday for Prophylaxis (preventative medical measure). Review of Resident R47's current care plan failed to include a focus, goal, or interventions for the Azithromycin oral tablets. During an interview completed on 4/15/26, at 1:20 p.m. the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) Employee E2 confirmed the care plan failed to include a focus, goal or intervention for the Azithromycin tablets and that the facility failed to ensure that a resident's care plan was updated and revised to reflect the resident's specific care needs for one of three residents (Residents R47). 28 Pa. Code 201.24(e)(1)(5) Admissions Policy28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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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 clinical records and staff interviews, it was determined that the facility failed to obtain physician orders for management of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) for one of two residents (Resident R64) and failed to procure complete physician's orders for one of two residents (Resident R47).Findings include: Review of the facility policy Nursing Care of the Resident with Diabetes Mellitus last reviewed 1/15/26, indicated the purpose of this guideline is to help the resident control his/her diabetes with diet, exercise and insulin as ordered, Prevent recurrent hyperglycemia (blood sugar above target levels) and hypoglycemia (blood sugar below target levels). Review of the facility policy Antibiotic Stewardship last reviewed 1/15/26, indicated antibiotics will be prescribed and administered to residents under the guidance of the facilities antibiotic stewardship program. If an antibiotic is indicated, prescribers will provide complete antibiotic orders including but not inclusive to the following elements:Drug nameDrug doseFrequency of administrationDuration of treatmentIndications for use. Review of the clinical record indicated Resident R64 was admitted to the facility on [DATE]. Review of Resident R64's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/2/26, indicated diagnoses of high blood pressure, diabetes (high sugar in the blood) and heart failure (heart doesn't pump the way it should). Review of Resident R64's physician orders dated 12/24/25, indicated Basaglar (long acting) insulin 20 units subcutaneously one time a day related to type two diabetes. Review of Resident R64's physician orders dated 3/19/26, indicated blood glucose monitoring in the morning for diabetes. The physician order failed to contain parameters for when to contact the physician regarding hypoglycemia or hyperglycemia. During an interview completed on 4/16/25, at 2:10 p.m. Licensed Practical Nurse (LPN) Employee E7 confirmed that the physician order failed to contain parameters for when to contact the physician and stated, I'm not sure why it doesn't have any and confirmed that the facility failed to obtain physician orders for management of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) for one of two residents (Resident R64). Review of Resident R47's clinical record indicated an admission date of 6/15/24. Review of R47's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/10/26, indicated the diagnosis of hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD- restricts breathing), and hyperlipidemia (high fats in the blood). Review of Resident R47's physician order dated 12/24/25, indicated Azithromycin Oral Tablet 250 milligram. Give 1 tablet by mouth one time a day every Monday, Wednesday and Friday for Prophylaxis (preventative medical measure). The order failed to include a diagnosis for the medication. During an interview completed on 4/15/26, at 1:20 p.m. the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) Employee E2 confirmed the orders failed to include a diagnosis and that the facility failed to procure complete physician's orders for one of two residents (Resident R47). 28 Pa. Code 211.10(a)(c) Resident policies.28 Pa. Code 211.12(d)(1)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Rehabilitation & Healthcare Center	100 Little Drive Lower Burrell, PA 15068

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, clinical record review, and staff interview, it was determined that the facility failed to conduct ongoing accurate assessments to ensure that bedrails were used to meet residents' needs and the risks associated with bedrail usage for two of five residents (Residents R3 and R7).Findings include: Review of facility policy Proper use of Bed Rails dated 1/15/26, indicated the resident assessment must assess the resident's risk from using bed rails. The resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself. A nurse assigned to the resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon a significant change in status, or a change in the type of bed/mattress/rail. Review of the clinical record revealed Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/25/26, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and muscle weakness. Review of Resident R3's comprehensive care plan revealed the resident has an ADL (activities of daily living) self-care deficit related to weakness/deconditioning, right below the knee amputation. Interventions include bilateral (both sides) enabler bars to assist with mobility. Review of Resident R3's clinical record revealed the last Enabler/Assist Rail/Device Evaluation - V2 assessment was completed 4/11/25. During an observation on 4/13/26, at 10:05 a.m. bilateral enabler bars were observed on top of Resident R3's bed. Review of the clinical record revealed Resident R7 was admitted to the facility on [DATE]. Review of Resident R7's MDS dated [DATE], indicated diagnoses of high blood pressure, hemiplegia (paralysis on one side of the body), and Cerebrovascular Accident (CVA - a stroke, blood flow to the brain is interrupted). Review of a physician order dated 10/20/25, indicated left enabler bar to assist in mobility and positioning. Review of Resident R7's comprehensive care plan revealed the resident has an ADL self-care deficit related to CVA with left sided paralysis. Interventions include left enabler/helpers rail. Review of Resident R7's clinical record revealed the last Enabler/Assist Rail/Device Evaluation - V2 assessment was completed 4/11/25.During an observation on 4/13/26, at 10:14 a.m. an enabler bar was observed on the left top of Resident R7's bed.During an interview on 4/17/26, at 10:25 a.m. the Assistant Director of Nursing (ADON) Employee E2 stated, Enabler bar assessments should be done quarterly. During an interview on 4/17/26, at 10:25 a.m. ADON Employee E2 confirmed that the facility failed to conduct ongoing accurate assessments to ensure that bedrails were used to meet residents' needs and the risks associated with bedrail usage for two of five residents (Residents R3 and R7). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to provide evidence medication regimen reviews (MRRs) were reviewed by the resident's attending physician monthly for two of five residents (Residents R3 and R8).Findings include: Review of facility policy Medication Regimen Review (Monthly Report) dated 1/15/26, indicated the consultant pharmacist performs a comprehensive medication regimen review (MRR) at least monthly. The MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences to medication therapy. Findings and recommendations are reported to the director of nursing, the attending physician, the medical director and if appropriate the administrator. Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing. Review of the clinical record revealed Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/25/26, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and muscle weakness. Review of Resident R3's MRR dated 11/11/25, indicated the following recommendation from pharmacist to physician:This resident has been using Sertraline (a medication used to treat depression) 200 mg (milligrams) by mouth daily since 1/2025 without a GDR (gradual dose reduction). If this therapy is required to prevent future depressive disorders, please document to that effect in your progress notes. Review of Resident R3's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 11/11/25. On 12/6/25, a psychiatric Certified Registered Nurse Practitioner (CRNP) addressed the MRR, stating, Continue same meds. On 12/8/25, a facility CRNP addressed the MRR with agree. Review of Resident R3's MRR dated 2/26/26, indicated the following recommendation from pharmacist to physician:This resident has been receiving the following psychotropic therapy: Hydroxyzine (a medication used to treat anxiety) 25 mg by mouth twice a day since 8/2025. Please review current medication regimen and doses to ensure resident is using the lowest possible dose with minimal side effects. Please review for Gradual Dose Reduction and document if any change in therapy is contra-indicated for this resident. Review of Resident R3's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 2/26/26. On 3/9/26, a psychiatric CRNP addressed the MRR, stating, Benefits outweigh the risk, due to anxiety. On 3/18/26, a facility CRNP addressed the MRR with agree. Review of the clinical record revealed Resident R8 was admitted to the facility on [DATE]. Review of Resident R8's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia, and schizoaffective disorder (a mental disorder in which a person experiences a combination of schizophrenia and mood disorder symptoms). Review of Resident R8's MRR dated 11/11/25, indicated the following recommendation from pharmacist to physician:This resident has been taking Olanzapine (a mood stabilizer) 2.5 mg by mouth daily since 5/2025 without a GDR. Could we attempt a dose reduction at this time to verify this resident is on the lowest possible dose? If not, please indicate response below. Review of Resident R8's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 11/11/25. On 12/5/25, a psychiatric CRNP addressed the MRR, stating, Patient has schizoaffective. Benefits outweigh the risk. On 12/8/25, a facility CRNP addressed the MRR with agree. Review of Resident R8's MRR dated 12/25/25, indicated the following recommendation from pharmacist to physician:This resident has been taking Seroquel (a mood stabilizer) 12.5 mg by mouth twice a day since 6/2025 without a GDR. Could we attempt a dose reduction at this time to verify this resident is on the lowest possible dose? If not, please indicate a response below. Review of Resident R8's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/25/25. On 1/9/26, a psychiatric CRNP addressed the MRR, stating, Disagree - benefits outweigh the risk. Review of Resident R8's MRR dated 3/30/26, indicated the following recommendation from pharmacist to physician:This resident has been taking Buspirone (a medication used to treat anxiety) 5 mg by mouth twice a day since 9/2025 without a GDR. Could we attempt a dose reduction at this time to verify this resident is on the lowest possible dose? If no, please indicate response below. Review of Resident R8's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 3/30/26. On 4/7/26, a facility CRNP addressed the MRR, stating, Disagree - has failed GDR in past - aggression. During an interview on 4/15/26, at 1:48 p.m. the Director of Nursing confirmed that the monthly medication regimen reviews were addressed by the facility and Psych services CRNPs and not the resident's attending physician for Residents R3 and R8. 28 Pa. Code: 201.14 (a) Responsibility of licensee.28 Pa. Code: 211.5(f) Medical records.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that an influenza immunization was offered to one of five residents (Resident R65).Findings include: Review of facility policy Influenza Vaccine dated 1/15/26, indicated all residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with the vaccinations against influenza. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized. For those who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record. A resident's refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record. Review of the clinical record indicated Resident R65 was admitted to the facility on [DATE]. Review of Resident R65's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/19/26, indicated diagnoses of high blood pressure, anxiety, and depression. Question O0250: Influenza Vaccine indicated Resident R65 did not receive the influenza vaccine in the facility for this year's influenza vaccination season. The reason for not receiving the vaccination was coded as 5 not offered. Review of Resident R65's clinical record revealed the resident had last received an influenza vaccine on 10/17/24. Review of Resident R65's clinical record failed to include documentation that an influenza vaccine was offered and administered or declined since 10/17/24. During an interview on 4/15/26, at 2:40 p.m. Infection Preventionist Employee E2 confirmed that the facility failed to make certain that an influenza immunization was offered to one of five residents (Resident R65). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.5(f) Medical records.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, observations, and staff interview, it was determined that the facility failed to make certain that equipment was in safe operating condition for one of two crash carts (East Hall Crash Cart).Findings include: Review of a facility document Basic Crash Cart Checklist indicated licensed nurse or designee completes checklist items against contents of crash cart (a cart maintained with equipment used in cardiac and respiratory emergencies) weekly and submits to the Director of Nursing (DON) upon completion. Items include an ambu mask and bag (a handheld device that delivers ventilation to patients who are not breathing). During an observation on [DATE], at 12:44 p.m. of the East Hall Crash Cart reveled the following:Two (2) ambu bags and masks, expired [DATE]. During an interview on [DATE], at 12:50 p.m. the DON confirmed the above observation and that the facility failed to make certain equipment was in safe operation condition for the East Hall Crash Cart. 28 Pa. Code: 201.14(a) Responsibility of licensee.