STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395481	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Center	1245 Church Road Wyncote, PA 19095

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 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. Based on review of facility policy, review of clinical record, review of facility documentation, and staff interview, it was determined that the facility failed to notify the resident representative of a transfer to the hospital for one of one resident reviewed for notification of changes (Resident R1).Findings include: Review of facility policy titled Discharge and Transfer last revised June 11, 2026, revealed the facility is required to immediately inform the resident and residents representative when a decision is made to transfer the resident. Further, the policy states that when immediate transfers are required due to the residents' urgent medical needs, notification must be provided as soon as practicable. Review of resident R1's clinical record revealed that the resident was transported to his/her scheduled outpatient dialysis treatment on June 19, 2026, and subsequently required a transfer to the hospital, for further evaluation. Further review of Resident R1's clinical record revealed no documented evidence Resident R1's representative, Power of Attorney (POA - legal tool that grants an individual the authority to make decisions and take actions on behalf of another person), was notified of the hospital transfer. Review of Resident R1's clinical record revealed a nursing progress noted June 19, 2026, at 6:04 PM documenting the resident was transported to his/her scheduled hemodialysis treatment via medical transport. During the dialysis treatment, the dialysis center notified the facility that Resident R1 had been transferred to the hospital due to left Arteriovenous Fistula complication (An AV Fistula is a surgically created connection between an artery and an and a vein that provides vascular access for hemodialysis. Complicate complications may include clotting, bleeding, infection, poor blood flow or malfunction which can interrupt dialysis treatment and require urgent medical evaluation). The nurse's note further documented that facility staff contacted the hospital and confirmed the resident had been admitted for evaluation and treatment of the left AV fistula. Review of facility documentation revealed Resident R1's representative became aware of the transfer only after arriving at the facility approximately two days later (June 21, 2026) to visit the resident, at which time staff informed Resident R1's representative that the resident had been transferred to the hospital on June 19, 2026. Interview with Nursing Home Administrator, Employee E1, on June 30, 2026, at approximately 10:00 AM revealed he/she was covering the facilities front desk on June 21, 2026, when the Resident R1's representative arrived to visit the resident. Nursing Home Administrator, Employee E1, explained it was at that time when Resident R1's representative was notified the resident had been transferred to the hospital two days ago, on June 19, 2026. Continued interview with Nursing Home Administrator, Employee E1, on June 30, 2026, at 10:00 a.m. confirmed Resident R1's representative was not notified of the resident's hospital transfer prior to his/her arrival at the facility on June 21, 2026. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.12 (d)(3) Nursing services

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395481	A. Building B. Wing	06/30/2026

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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. Based on review of clinical records, and staff interview it was determined that the facility failed to ensure care and services were provided in accordance with physician orders for one of one resident reviewed (Resident R1). Findings include: Review of Resident R1's discharge MDS (minimum data set - federally mandated resident assessment and care screening) dated June 19, 2026, revealed the resident was discharged to a short-term acute care hospital. Per the MDS, Resident R1 has a diagnosis of end stage renal disease (also known as kidney failure) and receives hemodialysis (a machine used to physically filter waste out of the blood). Review of Resident R1's physician orders revealed an order dated October 21st, 2025, directing staff not to obtain blood pressure measurements in resident's left arm.Review of Resident R1's clinical record revealed vital signs of documented blood pressure measurements that are repeatedly obtained in the resident's left arm on the following dates: 6/4/2026: BP (blood pressure) 137/76 left arm6/6/2026: BP 97/66 left arm6/11/2026: BP 150/68 left arm6/11/2026: BP 110/65 left arm6/14/2026: BP 138/77 left arm6/16/2026: BP 143/76 left arm6/16/2026: BP 102/66 left arm6/18 /2026: BP 117/63 left arm6/18/2026: BP 105/54 left arm6/26/2026: BP 148/72 left arm6/27/2026: BP 137/76 left arm Interview on June 30, 2026, at approximately 2:00 p.m. with Nursing Home Administrator, Employee E1, and Director of Nursing, Employee E2, confirmed that staff was documenting blood pressure readings from Resident R1's left arm despite a physician order directing staff not to. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(5) Nursing Services.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on review of facility policy, review of facility documentation, review of clinical records, and staff interview it was determined that the facility failed to maintain complete and accurate documentation one of two residents reviewed (Resident R1). Findings include: Review the facility policy titled Dialysis Hemodialysis Communication and Documentation last revised November 14, 2025, revealed the facility is responsible for maintaining ongoing communication and collaboration with the certified dialysis facility regarding the resident condition before and after each hemodialysis treatment the policy requires. A licensed nurse to complete the hemodialysis communication record including the pre dialysis evaluation before the resident leaves for dialysis. The dialysis facility to complete and return the communication form with the resident following treatment. Upon the resident return, a licensed nurse to review the dialysis facilities communication, assess the resident, and complete the post dialysis treatment evaluation. If the dialysis communication form is not returned, the facility must contact the dialysis center, request the information and document that communication. Review of facility dialysis service agreement between the facility and the contracted dialysis provider revealed the agreement requires ongoing communication and coordination of care between both parties. The agreement states the dialysis center will provide the facility with information regarding the resident's dialysis treatment fully and aspects of the resident's care related to the provision of the dialysis service. The agreement also requires the facility to ensure all pertinent medical information accompanies the resident to dialysis, including the resident's medical history, current treatments, medication changes, changes in condition, diet, fluid restrictions, laboratory findings, advanced directives, and any additional information necessary to facilitate coordination of care. The dialysis provider is required to maintain reports of services rendered, and the facility has the right to obtain copies of these records for inclusion in the resident's medical records to ensure continue the of care Review of resident R1's discharge Minimum Data Set (MDS - federally mandated resident assessment and care screening) date of June 19, 2026, revealed Resident R1 was discharged to a short-term acute care hospital. Per the MDS, Resident R1 has a diagnosis of end stage renal disease (also known as kidney failure) and receives hemodialysis (machine that filters the toxins from the blood) treatment. Review of Resident R1's dialysis communication records revealed incomplete and inconsistent documentation, including missing post dialysis vital signs, post dialysis weights and post treatment assessments. In addition, discrepancies were identified between the dialysis communication record and the documentation in the resident's electronic medical record. Continued review of Resident R1 hemodialysis communication record revealed the facility failed to consistently complete the required post dialysis nursing assessment upon the resident's return to the facility on the following dates: June 5, 2026, the post hemodialysis section to be completed by the facilities licensed nurse was not completed June 8, 2026, the post hemodialysis assessment section was not completed. June 10, 2026, the post hemodialysis assessment section was not completed. June 12, 2026, the post hemodialysis assessment section was not completed. June 17, 2026, neither the section to be completed by the certified dialysis nurse allowing treatment nor the post hemodialysis section to be completed by the facility licensed nurse was completed. June 26, 2026, the post hemodialysis assessment section to be completed by the facility's licensed nurse was not completed. Further review of Resident R 1's clinical record revealed the documented vital signs in the electronic medical record did not consistently correspond with the vital signs documented in the resident dialysis communication binder. Comparison of the two records identified discrepancies in the documented vital signs, as well as missing documentation in both the electronic record and the dialysis communication binder cord. Interview with Licensed Nurse, Employee E3, on June 30th, 2026, at approximately 1:00 p.m. confirmed that the dialysis communication binder was incomplete. 28 Pa Code 211.5 (f)(ii) Medical records.28Pa. Code 211.12 (d)(3) Nursing services.