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	04/16/2026

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

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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 0684 Level of Harm - 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, hospital records, and staff interviews, it was determined the facility failed to appropriately monitor and notify the physician of repeated critically elevated blood pressure readings and failed to ensure an anti-hypertensive medication was administered as ordered by the physician. This failure resulted in actual harm to Resident R12 who sustained uncontrolled hypertension, transferred to the hospital with a diagnosis of hypertensive urgency requiring hospital admission for one of 30 residents reviewed. (Resident R12)Findings include:Review of Resident R12's quarterly Minimum Data Set (MDS- federal mandated assessment tool) dated December 13, 2025, revealed the resident was admitted to the facility on [DATE]. The MDS identified diagnoses including Stroke (medical condition in which blood flow to a part of the brain is interrupted, resulting in brain cell damage that can affect movement, speech, and cognitive function), Anemia (condition characterized by a reduced number of red blood cells or hemoglobin, leading to decreased oxygen delivery throughout the body and symptoms such as fatigue and weakness), Hypertension (persistently elevated blood pressure, which increases the risk of cardiovascular complications), Renal Insufficiency (decreased kidney function, affecting the body's ability to filter waste and maintain fluid and electrolyte balance), and Hemiplegia (paralysis or significant weakness on one side of the body, commonly resulting from a stroke, and often impacts mobility and the ability to perform activities of daily living). Review of Resident R12's care plan revealed; Resident exhibits or is at risk for cardiovascular symptoms or complications related to the diagnosis of Hypertension. The care plan was initiated on May 7, 2019, and revised on December 30, 2025. The goal (revised April 10, 2024) indicated the resident's blood pressure will remain within baseline parameters. Interventions including administering medications as ordered, assessing for effectiveness and potential side effects, and reporting any abnormalities to the physician, was initiated on May 7, 2019. Additional interventions included assessing and monitoring vital signs as ordered and reporting abnormalities to the physician, initiated on May 7, 2019. Review of Resident R12's physician orders revealed an order to check blood pressure every six hours related to Hypertension, initiated on September 16, 2025. Review of Resident R12's December 2025 physician orders obtained revealed an order for Clonidine HCl 0.1 milligrams (mg) obtained May 1, 2024, to be administered by mouth every six hours as needed (PRN) for systolic blood pressure greater than 150 mmHg and/or diastolic blood pressure greater than 90 mmHg, initiated on May 1, 2024. Review of Resident R12's December 2025 Medication Administration Record (MAR) revealed the following elevated blood pressures readings (normal blood pressure range 120/80) and times. December 1: 168/85 (0000), 159/82 (0600) December 2: 186/82 (0000), 174/69 (0600), 153/77 (1800) December 3: 161/79 (0000), 158/80 (0600) December 4: 165/76 (0600) December 5: 183/90 (0000), 213/87 (1800) December 6: 211/82 (0000), 208/88 (0600) December 7: 178/80 (0000) December 8: 158/76 (1200) December 9: 246/121 (0000) December 10: 152/74 (0000), 156/67 (1200), 161/90 (1800) December 11: 170/80 (0000) December 12: 163/81 (0600), 132/90 (1800) December 13: 177/78 (0000), 153/87 (0600) December 14: 188/80 (0600) December 15: 182/87 (0000) December 16: 205/79 (0000) Review of the above blood pressure readings identified multiple instances in which the resident's blood pressure exceeded the physician ordered parameters. Review of Resident R12's (continued on next page)

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

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	December 2025 MAR (medication administration record) failed to reveal the medication Clonidine HCl 0.1 mg (PRN) was administered as prescribed during those times, despite the readings meeting the criteria for administration. Review of practitioner notes dated December 16, 2025, failed to reveal evidence the practitioner evaluated the effectiveness of the PRN Clonidine HCl 0.1 mg order or made adjustments to either PRN or routine antihypertensive medications in response to the documented elevated blood pressure readings. Review of nursing notes dated December 16, 2025, revealed the resident was transferred to the hospital emergency room. A documented call (by staff) to the hospital confirmed the resident was admitted with Hypertensive Urgency (Hypertensive Urgency is defined by the American Heart Association and American College of Cardiology as a severe elevation in blood pressure, typically a systolic blood pressure of ˆ180 mmHg and/or diastolic blood pressure of ˆ120 mmHg, without evidence of acute target organ damage). Interview with the Director of Nursing, Employee E2 on April 16, 2026, approximately 2:30 p.m. confirmed Clonidine HCl 0.1 mg was not administered as ordered. The Director of Nursing confirmed the physician was not notified despite the resident's multiple elevated blood pressure readings. The Director of Nursing, Employee E2 revealed that although there was no specific physician order requiring notification, the nursing staff should have notified the physician of Resident's E12's elevated blood pressure readings in accordance with professional standards of nursing practice and change in condition. The facility failed to appropriately monitor and notify the physician of repeated critically elevated blood pressures readings and failed to ensure anti-hypertensive medication was administered as ordered by physician. This failure resulted in actual harm to Resident R12 who sustained uncontrolled hypertension and subsequent transfer to the emergency department with a diagnosis of hypertensive urgency requiring hospital admission. 28 Pa. Code 211.2(d)(3)(9) Medical Director 28 Pa. Code 211.9(a)(1) Pharmacy Services 28 Pa. Code 211.10 (a)(c)(d) Resident Care Policies 28 Pa. Code 211.12 (d)(1)(2)(5) Nursing Services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and staff interview, it was determined that the facility failed to ensure that supervision was provided to one of 30 residents reviewed (Resident R4) and the safe temperature of hot beverages in one of three nursing floors (Third Floor)Findings include: Review of Resident R4's clinical records revealed that the resident was admitted to the facility on [DATE], the diagnoses of Impulse Disorder, Dementia (Progressive cognitive decline), Abnormal Gait/Mobility (Unsteady walking pattern). Review of Resident R4's April 2026 physician orders revealed an order obtained March 1, 2026, for one-to-one supervision, at all times, every shift. Review of the resident's care plan dated March 3, 2026, revealed 1:1 supervision initiated at time of escalation -February 27, 2026. Observation conducted on April 13, 2026, at 10:45 a.m. revealed Resident R4 was alone in the room without any nursing staff present providing 1:1 supervision. Observation conducted on April 14, 2026, at 9:23 a.m. revealed a staff member (Nurse Aide E23) providing 1:1 supervision to Resident R4. Nurse aide, Employee E23 was asked by the surveyor regarding no 1:1 supervision observed on April 13, 2026, at 10:45 am. Nurse Aide, E23 stated there was no staff coverage available at that time. Observation conducted on April 16, 2026, at 9:46 a.m., revealed Resident R4 in the (his/her) room attempting to get out of bed with both legs dangling off the left side of the bed. An individual (Employee E22) was observed attempting to assist the resident by moving the resident's legs from the left side of the bed back to the middle of the bed. On April 16, 2026, at 9:50 a.m., interview conducted with a individual (Employee E22) revealed that she was not assigned as the 1:1 staff for the resident. Employee E22 identified herself as an occupational therapist for the resident's roommate, stated she is employed by an outside company, and stated she attempted to assist the resident because she did not want the resident to fall. Interview on April 16, 2026, 9:52 am, with the Unit Manager (Nurse E4) confirmed the resident required continuous 1:1 supervision and confirmed there was no staff present in the resident's room providing 1:1 supervision at the time of observation on April 13, 2026, at 10:45 a.m. Review of facility hot beverage temperature logs revealed instructions that after preparing a hot beverage, measure and record the initial temperature immediately after preparation. Per the distribution process instructions, hot beverages should be held until the temperature is in range of 120 to 150 degrees Fahrenheit before delivering to the nursing station. Once temperature is within temperature range of 120 to 150 degrees Fahrenheit, the dietary employee will document the delivery temperature, time of delivery, and their signature on the log. Observation in the third-floor dining room on April 15, 2026, at approximately 12:15 p.m. revealed 14 residents were present at the time in the dining room. An activities assistant was observed distributing coffee and cautioned one resident by stating, Careful, it's hot. Visual observation of the coffee showed steam rising from the top of the cup. Interview with the Activity assistant, Employee E20 at the time of the observation revealed that when asked about the coffee temperature, she stated, We don't take the temperature of the coffee. Observations on April 15, 2026, at 12:35 p.m. the Regional Dietary Manager, Employee E16, poured a cup of coffee from the third-floor dining room beverage dispenser and obtained a temperature of 165 degrees. Review of the hot beverage log for April 15, 2026, revealed the lunch coffee delivery temperature was documented as 145 degrees at 11:30 a.m. The log did not specify which floor this was for. Interview on April 15, 2026, at 12:40 p.m. with Dietary Aide, Employee E17, revealed he/she did not check the temperature of the coffee delivered to the third-floor dining room before delivery. Dietary aide, Employee E17, reported the third-floor insulated coffee beverage dispenser was prepared pretty fresh before delivery. Interview on April 15, 2026, at 12:54 p.m. with the Regional Dietary Manager, Employee E16, reported that the coffee brews at 200 degrees Fahrenheit. 28 Pa Code 201.18(b)(3) Management 28 Pa. Code 211,10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interview and review of professional medical information, it was determined that the facility failed to ensure that four of four licensed nursing staff were knowledgeable in stoma/colostomy care. (Employees E5, E6, E7, and E10)Findings include: Review of the National library of Medicine article titled Intestinal Stoma last updated June3, 2023, revealed an intestinal stoma (colostomy or ileostomy) is a surgically created opening of the bowel through the abdominal wall and is a common, often life-saving procedure used to treat conditions such as colorectal cancer, bowel obstruction, and inflammatory bowel disease. Although stomas are common, they are associated with a high rate of complications (10-70%), including infection, retraction, prolapse, ischemia, fistula formation, and fluid/electrolyte imbalances. These complications can significantly impact the resident's health and require ongoing assessment, clinical judgment, and intervention. Care of a stoma is not limited to basic hygiene or appliance changes. Management often requires: Recognition of abnormal stoma appearance and complicationsUse of specialized supplies (barrier systems, rings, powders, advanced dressings)Understanding of bowel function, output changes, and risk of dehydrationTimely clinical decision-making and provider notificationThe literature emphasizes that stoma care requires an interdisciplinary approach, including trained nursing staff and, when needed, wound/ostomy specialists. Both preoperative and postoperative education are critical to ensure safe and effective care and to reduce complications. Review of facility assessment for Resident Population Profile April 10, 2025, through April 9, 2026, revealed 4.4% of admissions/stays include residents with an ostomy (urostomy, ileostomy, colostomy). Interview on April 16, 2026, at 11:40 a.m. with Nurse Practice Educator, Employee E7, revealed a skills fair was held in October 2025 which included a review of ostomy care. Continued interview on April 16, 2026, at 11:40 a.m., Nurse Practice Educator, Employee E7, confirmed Resident R106 had a colostomy. Nurse Practice Educator, Employee E7, was unaware of any special care needs for Resident R106's colostomy. Further interview on April 16, 2026, at 11:40 a.m. with Nurse Practice Educator, Employee E7, revealed there was no process for confirming hands-on skills evaluations for agency nursing staff. Review of facility documentation and staff interview revealed Licensed Nurse, Employee E5, and E10 were agency nurse staff. Licensed Nurse, Employee E6, was hired by the facility in February 2026. Review of facility education documentation revealed no evidence that Licensed Nurse Employee E5, E6, and E10 received any skills competency evaluations to ensure competency of hands-on skills and techniques necessary for colostomy care. Interview on April 16, 2026, at 11:40 a.m. the Nurse Practice Educator, Employee E7, confirmed that no hands-on skills evaluations for Employees E5, E6 and E10 related to colostomy care were available for review at the time of the survey. Review of the Resident R106's Minimum Data Set (MDS- a federal mandated assessment tool for all residents), dated March 16, 2026, revealed the resident was admitted to the facility on [DATE], with a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident required supervision or touching assistance with activities of daily living (ADLs) and had diagnoses including colostomy status (a surgically created opening (stoma) in the abdominal wall that allows stool to exit the body into an external pouching system) and polyneuropathy (a condition involving damage to multiple peripheral nerves, which can result in weakness, numbness or decreased sensation, and impaired coordination and fine motor skills). Review of Resident R106 April 2026 physician's orders revealed orders for colostomy care every shift and as needed, monitor stoma for changes and notify physician, and peri-stomal wound care, including cleansing, application of ointment, dressing changes and the antibiotic treatment Clindamycin 300 milligrams. Interview with Resident R106 on April 13, 2026, at 11:20 am, revealed this resident reported having a complex colostomy that (she/he) described as herniated and prolapsed, measuring approximately 6-8 inches, which made management (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	difficult, particularly due to limited hand function. The resident stated that colostomy care typically required assistance from at least one staff member. Resident R106 further reported that staff were inconsistent in both their ability to provide colostomy care. While a few staff members were identified as helpful, the resident stated that only certain staff were knowledgeable in performing colostomy care, and those staff were not consistently available. During interview Resident R106 described that some staff assigned to provide care lacked knowledge of colostomy management, including proper handling of the appliance and overall care needs. Additionally, the resident stated that although she was informed that all nursing staff were trained in colostomy care, this was not reflected in actual care delivery, resulting in difficulty managing the colostomy and reliance on a limited number of available staff. Observation of Resident R106 at time of interview on April 13, 2026, confirmed that the resident had a prolapsed colostomy stoma characterized by a beefy red segment of bowel extending approximately 8 inches beyond the abdominal wall and positioned within a colostomy appliance. Interview with Licensed nurse, Employee E6 on April 14, 2026, at 1:00 p.m., who was the assigned nurse for Resident R106, stated she is competent in changing a colostomy bag but unsure of the technique and additional care required for this resident. Interview with Licensed Nurse Educator, Employee E7 on April 16, 2026, at 2:00 p.m. confirmed that she is responsible for staff education, including colostomy care. She stated that the resident did not require specialty care and that all nursing assistants and licensed nurses have been educated and are competent to provide colostomy care in accordance with professional standards, including care for this resident. Licensed nurse educator, Employee E7 further stated that she is knowledgeable and capable of performing colostomy care. Licensed Nurse Educator, Employee E7 was asked to demonstrate colostomy care for Resident 106. Licensed Nurse Educator, Employee E7 stated that she could provide complete and appropriate care for the resident. However, upon observation on April 14, 2026, at 1:00 p.m. of the resident's stoma, which presented with an unusual appearance, Licensed nurse educator, Employee E7 was unable to proceed with the colostomy care at that time. She stated that she needed to review the resident's medical record and consult additional resources prior to providing care. Licensed nurse educator, Employee E7 subsequently stated that this specific type of colostomy would require additional staff education to ensure proper care and assessment. 28 Pa. Code 201.19(2)(3)(7) Personnel Records28 Pa. Code 201.20(a)(6)(b)(d) Staff Development 28 Pa. Code 201.29(4) Resident Rights28 Pa. Code 211.10(b)(c)(d) Resident Care Policies 28 Pa. Code 211.12(d)(1)(4)(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 observation and review of facility policy, it was determined that the facility failed to ensure that medications were properly stored and disposed on two of three nursing units. (1st and 3rd floors) Findings include: Review all facility policy titled Medication Storage storage of medication the the January of twenty 6 revealed medication biologicals are stored properly following manufacturers or provider pharmacy recommendations to keep their integrity and to support safe, effective drug administration the medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications.Medications requiring storage at room temperature or captive temperatures ranging from 59 degrees Fahrenheit to 77 degrees Fahrenheit. Controlled room temperature is defined as 68 degrees Fahrenheit 77 degrees Fahrenheit excursions between 59 degrees Fahrenheit to 86 degrees Fahrenheit are layout with transit spikes to 104 degrees Fahrenheit as long as they don't exceed 24 hoursMedications requiring refrigeration or temperatures between 36 degrees Fahrenheit and 46 degrees Fahrenheit are kept in any refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage in a cool place may be refrigerated unless otherwise directed on the label as cool temperatures are those between 46 degrees Fahrenheit and 59 degrees Fahrenheit a temperature log or tracking mechanism is maintained to verify the temperature has remained within acceptable limits. The temperature of any refrigerator that stores vaccine should be monitored and recorded twice daily.Insulin products should be stored in the refrigerator until open. Note the date on the label for insulin vials and pens when first used. The open insulin vial may be stored in the refrigerator or at room temperature. Open insulin pen should be stored at room temperature.Refrigerator medications should be kept enclosed and labeled containers, with internal medications separated from external medications and all medications segregated from fruit juices applesauce and other foods used in administering medications. Any other food such as employee lunches and activity department refreshments should not be stored in this refrigerator. The refrigerator should be kept clean and frost free to protect refrigerated medications from freezing stir them away from the freezer section A review of the facility's January 2026 ?Medication Storage' policy indicates that medications and biologicals must be stored according to manufacturer or pharmacy guidelines to maintain integrity and ensure safe administration. Access to medications is restricted to authorized personnel. Room-temperature medications are maintained within defined ranges, and refrigerated medications are stored between 36 F and 46 F with continuous temperature monitoring and documentation. Vaccine storage temperatures are recorded twice daily. Insulin is refrigerated until opened, with specific storage guidelines thereafter. All refrigerated medications must be properly labeled, separated by type, and kept apart from food items, with refrigerators maintained in a clean, frost-free condition to prevent contamination or temperature compromise. Observation of 3rd floor medication room accompanied with Licensed nurse, Employee E7 on April 13, 2026, at 9:30 am revealed, the temperature log that records daily temperatures of the refrigerator revealed that the log was dated July of 2025. Inside the medication refrigerator was observed an employee lunch bag, and the following medications: -Novolin insulin dated January 2026 -Lanzapizole dated February 2026-Multi use insulin bottle without no date Observation of the medication storage room on the 1st Floor on April 13, 2026, at 10:40a.m. with Licensed staff, Employee E4, revealed two bottles of Vitamin B12 500 microgram (mcg) with an expiration date of January 2026. Observation of the medication refrigerator on the 1st floor revealed no record of temperature of the refrigerator. The temperature recorded inside the refrigerator at the time of the observation was 39-degree Fahrenheit. Interview with Licensed staff, Employee E4 at the time of the observation confirmed the above findings. 28 Pa Code 211.12(d)(1) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review facility documentation, review of clinical records, observations, and staff interviews, it was determined that the facility failed to ensure residents with limited range of motion received treatment and services to maintain or improve range of motion/mobility for one of three residents reviewed with limited range of motion (Resident R93).Findings Include: Review of facility policy Restorative Nursing revised August 7, 2023, revealed restorative programs are coordinated by nursing or in collaboration with rehabilitation and are patient specific based on individual patient needs. Review of Resident R93's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated March 4, 2026, revealed the resident was assessed with a BIMS of 12 and had diagnoses of hemiplegia or hemiparesis (weakness to one side of the body) and malnutrition. Review of Resident R93's comprehensive care plan dated April 10, 2025, revealed the resident was at risk for alterations in comfort related to left side flaccidity and immobility. Interventions dated April 10, 2025, included assist resident to a position of comfort utilizing positioning devices. Review of Resident R93's occupational therapy Discharge summary dated [DATE], revealed Resident R93 was able to wear a resting hand splint on the left hand for up to 4 hours. Review of Resident R93's Restorative Nursing Program Goals dated December 3, 2025, revealed occupational therapy recommended Resident R93 wear a left-hand splint daily for 4-6 hours with skin checks pre and post wearing. Recommendations also included that Resident R93 perform daily upper and lower extremity active range of motion. Further review of Resident R93's Restorative Nursing Program Goals dated December 3, 2025, revealed Registered Nurse, Employee E13, was trained in the procedures for the restorative nursing program and signed and acknowledged the recommendations. Observations on April 13, 2026, at 11:53 a.m. revealed Resident R93 had a contracture to the left hand. On the wall next to Resident R93's bed was a picture of a splint with instructions to apply the splint to the left hand daily and perform skin checks before / after applying the splint. Resident R93 did not have the splint on and reported staff do not apply it. Follow-up observations on April 16, 2026, at 10:15 a.m. revealed Resident R93 was not wearing the splint. Interview on April 16, 2026, at 10:20 a.m. with Director of Rehabilitation, Employee E14, confirmed Resident R93's splint should be applied daily. Interview on April 16, 2026, at 10:25 a.m. with Resident R93's assigned Licensed nurse, Employee E15, confirmed Resident R93 was not wearing the splint. Licensed nurse, Employee E15, reported no physician order was in Resident R93's clinical record for a splint. Continued interview on April 16, 2026, at 10:25 a.m. with Licensed nurse, Employee E15, revealed Resident R93 was going to be referred to therapy to evaluate use and splint and obtain a physician order. Interview on April 16, 2026, at 10:50 a.m. with Director of Rehabilitation, Employee E14, revealed therapy recommended use of a left-hand splint for Resident R93 in December 2025. Per the Director of Rehab, Employee E14, the hand splint was never discontinued by therapy and should have been used daily since December 2025 recommendation. Review of Resident R93's entire clinical record revealed no documented evidence the restorative nursing program recommendations were implemented. There was no documented evidence that Resident R93's splint was applied daily with subsequent skin checks from December 3, 2025, through April 16, 2026. 28 Pa. Code 211.12 (d)(3) Nursing services.28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of facility policy, observations, and staff interviews it was determined that the facility failed to maintain infection control practices related to collection and transport of biohazards on one of three nursing units (2nd floor).Findings Include: Review of facility policy Collection and Transport of Specimens revised March 20, 2026, revealed that specimen collection items are kept in a separate area away from food, medications, and other items. Observations on April 13, 2026, at 10:20 a.m. revealed consultant lab tech, Employee E19, was holding a biohazard specimen transport pouch with a vial of blood enclosed in the bag. Lab tech, Employee E19, proceeded to hold the biohazard specimen pouch inside a cooler filled with ice [located at the 2nd floor nurses station] and used the ice scoop to pour ice into the biohazard specimen pouch enclosed with a vial of blood. Interview on April 13, 2026, at 10:20 a.m. surveyor asked lab tech, Employee E19, if this is how he/she should be preparing the vial of blood for transport to which the lab tech, Employee E19, replied it was normal practice. Interview on April 13, 2026, at 10:25 a.m. with Registered Nurse, Employee E7, revealed the cooler of ice was intended to be used for resident drinking water, and subsequently should not be used for blood specimen samples. Registered Nurse, Employee E7, promptly removed the ice chest from the nursing unit. 28 Pa. Code 201.14 (a) Responsibility of licensee.28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on review of facility policy, review of facility documentation, review of grievances, and interviews with residents and staff, it was determined that the facility failed to ensure a sanitary, and homelike environment for one of three nursing units (2nd floor) Findings include:During an initial tour of the 2nd floor on April 13, 2026, at 11:15 a.m. there was a strong feces odor in the back hallway. Observations on April 13, 2026, at 11:50 a.m. revealed Resident R93's toilet was covered in feces. Resident R93 reported accidentally making a mess on the toilet overnight. Interview on April 13, 2026, at 11:56 a.m. with nurse aide, Employee E18, confirmed Resident R93's toilet was observed to be covered in feces at the start of his/her shift at 7:00 a.m. Observations on April 16, 2026, at 10:15 a.m. on the 2nd floor revealed meal trays from breakfast (consisting of eggs, and pudding) were left on the counter in the nourishment room. Further observations revealed a hole in the wall behind the sink. 28 Pa. Code 201.18(2.1) Management

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	04/16/2026

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation and resident interview, the facility failed to ensure that the environment remains free of pest for one on three dining rooms. (3rd floor) Findings include:Interview with Resident 1 on April 13, 2026, revealed concerns regarding the presence of pests in the facility. The resident reported repeatedly observing mice in her room and provided photographic documentation supporting the presence of rodents within the living environment. Interview with Resident 154 on April 15, 2026, at approximately 12:00 p.m. in the third-floor dining room revealed concerns regarding pest activity within the facility. The resident stated that mice are frequently observed throughout the unit and reported that the issue has been ongoing for several months without resolution. The resident further stated that he observed a mouse earlier that day in the dining room under the PTAC (packaged terminal air conditioner) unit. 28 Pa Code 201.18(b)(3)(e)(1)(2.1) Management