

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395208	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/12/2024
NAME OF PROVIDER OR SUPPLIER: HILLCREST REHABILITATION & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 LITTLE DRIVE LOWER BURRELL, PA 15068		
STATE LICENSE NUMBER: 021002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on an Abbreviated Survey in response to a complaint, completed on December 12, 2024, it was determined that Belair Healthcare and Rehabilitation Center was in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities; however, the facility was not in compliance with the 28. Pa Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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H 0009	<p>51.3 (g)(1-14) NOTIFICATION</p> <p>51.3 Notification</p> <p>(g) For purposes of subsections (e) and (f), events which seriously compromise quality assurance and patient safety include, but not limited to the following:</p> <p>(1) Deaths due to injuries, suicide or unusual circumstances.</p> <p>(2) Deaths due to malnutrition, dehydration or sepsis.</p> <p>(3) Deaths or serious injuries due to a medication error.</p> <p>(4) Elopements.</p> <p>(5) Transfers to a hospital as a result of injuries or accidents.</p> <p>(6) Complaints of patient abuse, whether or not confirmed by the facility.</p> <p>(7) Rape.</p> <p>(8) Surgery performed on the wrong patient or on the wrong body part.</p> <p>(9) Hemolytic transfusion reaction.</p> <p>(10) Infant abduction or infant discharged to the wrong family.</p> <p>(11) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence.</p> <p>(12) Notification of termination of any services vital to continued safe operation of the facility or the</p>	H 0009	<p>Immediate Action- The report was placed to the DOH ERS during the survey with the surveyor on 12/12/2024</p> <p>Education-The NHA and Maintenance Director were educated on the DOH reporting guidelines.</p> <p>Audits: Walking rounds will be completed 3 times weekly for 3 weeks and monthly times 1 month to ensure all utilities are in good working order.</p>	<p>Completion Date: 12/23/2024</p> <p>Status: APPROVED</p> <p>Date: 12/18/2024</p>

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Pennsylvania Department of Health

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H 0009	Continued from page 1 health and safety of its patients and personnel, including, but not limited to, the anticipated or actual termination of electric, gas, steam heat, water, sewer and local exchange of telephone service. (13) Unlicensed practice of a regulated profession. (14) Receipt of a strike notice. This REGULATION is not met as evidenced by:	H 0009		

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H 0009	<p>Continued from page 2</p> <p>Based on facility reports, and staff interview it was determined that the facility failed to notify the Department of Health with a Significant Disruption of Service Due to Disaster Such as Fire, Storm, Flood or Other Occurrence.</p> <p>Findings include:</p> <p>During a review of documentation provided by the facility on 12/12/24, at 9:53 a.m. failed to reveal that the therapy gym heating system was not in working order. Facility monitored temperatures in the therapy gym. When temperatures dropped below 71 degrees, the resident 's therapy was provided in alternative places. The facility heating system was replaced on 12/9/24.</p> <p>During an interview on 12/12/24, at 10:35 a.m. Nursing Home Administrator (NHA) stated, "We have a purchase order dated November for a new heating system for the therapy gym and they came in this week and replaced it".</p>	H 0009		

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H 0009	Continued from page 3 During an interview on 12/12/24, at 10:55 a.m. NHA confirmed that the facility failed to notify the Department of Health with a Significant Disruption of Service Due to Disaster Such as Fire, Storm, Flood or Other Occurrence.	H 0009		



Certified End Page

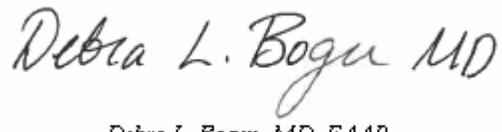
HILLCREST REHABILITATION & HEALTHCARE CENTER

STATE LICENSE NUMBER: 021002

SURVEY EXIT DATE: 12/12/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY