STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395620	A. BLDG: 00 B. WING:	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CEDAR HILL HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **232702**	**951 BRODHEAD ROAD CORAOPOLIS, PA 15108**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 1/30/25, it was determined that Cedar Hill Healthcare and Rehabilitation was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0880 SS=D		F 0880		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395620	A. BLDG: __00_____ B. WING: _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CEDAR HILL HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **232702**	**951 BRODHEAD ROAD CORAOPOLIS, PA 15108**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=D	Continued from page 1 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	1. All residents in rooms 227-236 have been assessed by the DON to ensure that no harm has occurred by not wearing appropriate PPE in their rooms. No findings noted. 2. All Covid isolation rooms have been assessed to ensure that they have the appropriate signage outside of their rooms and orders. 3. IP or Designee will educate Employees on the appropriate PPE to wear in isolation rooms. 4. DON or designee will audit 5 covid isolation rooms for 4 weeks to ensure that staff are wearing appropriate PPE. All findings will be reported to QAPI.	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/05/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395620	A. BLDG: __00_____ B. WING: _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CEDAR HILL HEALTHCARE AND REHABILITATION CENTER	**951 BRODHEAD ROAD CORAOPOLIS, PA 15108**
STATE LICENSE NUMBER: **232702**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=D	Continued from page 2 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395620	A. BLDG: __00_____ B. WING: _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CEDAR HILL HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **232702**	**951 BRODHEAD ROAD CORAOPOLIS, PA 15108**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=D	Continued from page 3	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395620	A. BLDG: __00_____ B. WING: _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CEDAR HILL HEALTHCARE AND REHABILITATION CENTER	**951 BRODHEAD ROAD CORAOPOLIS, PA 15108**
STATE LICENSE NUMBER: **232702**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=D	Continued from page 4 Based on review of facility policy, resident clinical records, observations, and staff interviews, it was determined that the facility failed to use Personal Protective Equipment (PPE) appropriately, which created the potential for the cross-contamination and the spread of diseases and infections in two out of 18 droplet precautions (infection control measures designed to prevent the spread of infectious diseases that are transmitted through respiratory droplets) rooms. (Covid and Exposed Unit). Findings include: Review of facility policy "Isolation Procedure: Resident placement in Transmission-Based Precautions" dated 4/17/24, indicated transmission-based precautions (including droplet) will be implemented when indicated by suspicion or presence of infectious disease. Initiate precautions as indicated. Review of facility policy "Personal Protective	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395620	A. BLDG: __00_____ B. WING: _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CEDAR HILL HEALTHCARE AND REHABILITATION CENTER	**951 BRODHEAD ROAD CORAOPOLIS, PA 15108**
STATE LICENSE NUMBER: **232702**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=D	Continued from page 5 Equipment" dated 4/17/24, indicated personal protective equipment (PPE) is available at all times. PPE includes gowns, gloves, masks, eyewear. Review of facility policy "Coronavirus (Covid-19) policy" dated 4/17/24, indicated facility leadership and clinical staff are implementing all reasonable measures to protect the health and safety of residents and staff during the current outbreak of coronavirus disease. Managing a confirmed or suspected Covid-19 individual: Staff entering or caring for the patient should follow recommendations for PPE. During a tour of facilities covid and exposed to covid unit, that included rooms 227 through 236, on 1/30/25, at 10:45 a.m. revealed each room with droplet isolation signage by resident ' s door, and PPE available for usage. During an observation on 1/30/25, at 10:55 a.m. Housekeeper Employee E2 was cleaning room and failed to wear appropriate droplet precaution PPE	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395620	A. BLDG: __00_____ B. WING: _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CEDAR HILL HEALTHCARE AND REHABILITATION CENTER	**951 BRODHEAD ROAD CORAOPOLIS, PA 15108**
STATE LICENSE NUMBER: **232702**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=D	Continued from page 6 (gown, gloves, mask, eyewear). During an observation on 1/30/25, at 11:00 a.m. Nurse Assistant (NA) Employee E3 was finishing providing care to a resident and failed to wear appropriate droplet precaution PPE. During an interview on 1/30/25, at 11:07 a.m. NA Employee E3 stated that she should have had a gown, gloves, N-95 mask (respirator mask used for droplet isolation), and eyewear on when entering a room with droplet isolation signage hanging by the door. During an interview on 1/30/25, at 11:10 a.m. Registered Nurse Employee E2 confirmed that staff should be wearing N-95 mask, gown, gloves, and face covering when entering droplet isolation rooms. A review of resident ' s clinical record of residents residing in rooms 227 through 236 on 1/30/25, at 12:15 p.m. all had current physician orders for droplet isolation, testing of covid, and care plans	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395620	A. BLDG: __00_____ B. WING: _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CEDAR HILL HEALTHCARE AND REHABILITATION CENTER	**951 BRODHEAD ROAD CORAOPOLIS, PA 15108**
STATE LICENSE NUMBER: **232702**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=D	Continued from page 7 where updated to reflect isolation needs. During an interview on 1/30/25, at 1:15 p.m. Director of Nursing confirmed that the facility failed to use Personal Protective Equipment appropriately, which created the potential for the cross-contamination and the spread of diseases and infections in two out of 18 droplet precautions rooms. (Covid and Exposed Unit). 28 Pa. Code: 201.14(a) Responsibility of licensee.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395620	A. BLDG: 00 B. WING:	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CEDAR HILL HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **232702**	**951 BRODHEAD ROAD CORAOPOLIS, PA 15108**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
H 0009	51.3 (g)(1-14) NOTIFICATION 51.3 Notification (g) For purposes of subsections (e) and (f), events which seriously compromise quality assurance and patient safety include, but not limited to the following: (1) Deaths due to injuries, suicide or unusual circumstances. (2) Deaths due to malnutrition, dehydration or sepsis. (3) Deaths or serious injuries due to a medication error. (4) Elopements. (5) Transfers to a hospital as a result of injuries or accidents. (6) Complaints of patient abuse, whether or not confirmed by the facility. (7) Rape. (8) Surgery performed on the wrong patient or on the wrong body part. (9) Hemolytic transfusion reaction. (10) Infant abduction or infant discharged to the wrong family. (11) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence. (12) Notification of termination of any services vital to continued safe operation of the facility or the	H 0009	1. All Covid-19 positives have been reported to the DOH through the ERS system. 2. The NHA or designee will complete a look back to ensure that all Covid-19 positives within the last 30 days have been reported. 3. The Regional NHA will educate the NHA and DON on reporting all cases of Covid-19. 4. The NHA or designee will audit that all new Covid-19 cases are reported to the DOH for the next month. All findings will be reported to QAPI.	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/05/2025**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395620	A. BLDG: __00_____ B. WING: _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CEDAR HILL HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **232702**	**951 BRODHEAD ROAD CORAOPOLIS, PA 15108**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395620	A. BLDG: 00 B. WING:	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CEDAR HILL HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **232702**	**951 BRODHEAD ROAD CORAOPOLIS, PA 15108**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
H 0009	Continued from page 2 Based on facility reports, and staff interview it was determined that the facility failed to notify the Department of Health with all health department reportable diseases. Findings include: During a review of documentation provided by the facility on 1/30/25, at 1:00 p.m. failed to reveal all positive Covid-19 (a contagious respiratory illness) for facilities current outbreak that included four residents. During an interview on 1/30/25, at 1:05 p.m. Nursing Home Administrator (NHA) stated, "I didn ' t think that we had to report all positive Covid-19, only the initial report". During an interview on 1/30/25, at 1:08 p.m. NHA confirmed that the facility failed to notify the Department of Health with all health department reportable diseases.	H 0009		

Certified End Page

CEDAR HILL HEALTHCARE AND REHABILITATION CENTER

STATE LICENSE NUMBER: 232702

SURVEY EXIT DATE: 01/30/2025

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
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