



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail hillsidemanorpch@gmail.com

Mailing Date: March 11, 2020

Mr. James E. Stambaugh II
Administrator / Owner
Hillside Manor Personal Care Home, Inc.
177 Oliver Road
Uniontown, Pennsylvania 15401

RE: Hillside Manor Personal Care Home
License #: 467990

Dear Mr. Stambaugh:

As a result of the Department's Bureau of Human Services Licensing inspection on September 24, 2019 and September 25, 2019, of the above facility, the citations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Sincerely,

A handwritten signature in black ink, appearing to read "Jason Williams".

Jason Williams
Human Services Licensing Supervisor

Enclosure
Violation Report

Violation Report

Facility Information

Name: *HILLSIDE MANOR PERSONAL CARE HOME*
Address: *177 OLIVER ROAD,, UNIONTOWN, PA 15401*
County: *FAYETTE* Region: *WESTERN*

License Number: *46799*

Administrator

Name: *Jim Stambaugh* Phone: *7244392273* Email: *HILLSIDEMANORPCH@GMAIL.COM*

Legal Entity

Name: *HILLSIDE MANOR PERSONAL CARE HOME INC*
Address: *177 OLIVER ROAD, UNIONTOWN, PA, 15401*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: Issued By:

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *53* Waking Staff: *40*

Inspection

Type: *Partial* BHA Docket #: Notice: *Unannounced*
Reason: *Complaint*

Inspection Dates and Department Representative

09/24/2019 - On-Site: Belinda Graziano, Courtney Barry

09/25/2019 - On-Site: Belinda Graziano

11/01/2019 - Off-Site: Belinda Graziano

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *76* Residents Served: *50*

Secured Dementia Care Unit

In Home: *No* Area: Capacity: Residents Served:

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *50*
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *3* Have Physical Disability: *1*

16c - Written Incident Report

Regulations

2600.

- 16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

The assessment and support plan for resident #1, dated 8/27/19, indicates the resident requires assistance with supervision and that the "Resident was an elopement risk at the other facility. He should not leave the facility unattended."

On 8/29/19, from 10:53 a.m. until 5:00 p.m, resident #1 left the home unattended without the home's knowledge.

On 8/31/19 from 7:35 a.m. until 12:42 p.m., resident #1 left the home unattended without the home's knowledge. During this time, resident #1 had an unwitnessed fall in a parking lot and was found by the police and taken to the local emergency room for treatment.

On 8/12/19, at approximately 5:00 a.m., resident #2 pushed resident #3 out of the bed which resulted in resident #3 sustaining a fractured ankle.

None of these incidents were reported to the Department.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See attached (page 3a of 4)

Legal Entity Representative

James E Stambaugh
Signature

James E Stambaugh
Printed Name and Title
Administrator

11/23/19
Date

16c - Written Incident Report (continued)

The above plan of correction is approved as of	3/9/20 (Date)	Plan of correction implementation status as of	3/9/20 (Date)
The above plan of correction was approved by	<i>JW</i> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented	

2600.16c

The incident on 8/29/19 was reported to DHS per regulation. See attached copy of email confirmation of submission of incident report.

The incident on 8/31/19 was not reported. The resident was not absent for greater than 24 hours and was not found by the police. A bystander saw resident fall in the parking lot and called 911. A incident report was not completed because the police were not involved, the resident was not absent for greater than 24 hours and the resident did not have any serious injuries. The resident was evaluated in the ER then returned to facility the same day. Effective immediately: A incident report will be submitted within 24 hours for any circumstances when a resident wanders from facility and requires medical attention. Facility supervisor or CRNP are responsible for submitting the report.

The incident on 8/12/19 was not reported because resident #2 and resident #3 were [REDACTED] Effective immediately: ANY incident ([REDACTED]) that results in significant or substantial injury will be reported to DHS within 24 hours. Facility supervisor or CRNP are responsible for submitting the report.

Incident reporting will be discussed at Quality Management

AND E Shubert
administrator
11/23/19

42b - Abuse

Regulations

- 2600.
- 42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

The assessment and support plan, dated 8/27/19, for resident #1 indicates the resident requires assistance with supervision and that the "Resident was an elopement risk at the other facility. He should not leave the facility unattended." On 8/29/19, from 10:53 a.m., until 5:00 p.m., the resident left the home unattended. On this day, the resident walked down the street to purchase a car. The seller of the car took the resident to the bank where the resident withdrew cash. The resident was later picked up by the home at the local emergency room with an altered level of consciousness and returned to the home. On 8/31/19, from 7:35 a.m. until 12:42 p.m., the resident left the home unattended. The resident had an unwitnessed fall and was found lying in a parking lot, approximately 2 miles from the home, by the local police. The resident had sustained a mild head injury with pain and was transported by police to the local emergency room and then returned back to the home.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See attached (Page 4a of 4)

Legal Entity Representative

James E Stanbough
Signature

James E Stanbough
Printed Name and Title *administrator*

11/23/19
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of	<u>3/9/20</u> (Date)	Plan of correction implementation status as of	<u>3/9/20</u> (Date)
The above plan of correction was approved by	<i>JW</i> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented	

2600.42.b

The resident was previously at another PCH and wandered away numerous times. The resident was not receiving medications properly. The resident is currently being followed by a psychiatrist and medications were being adjusted for the management of behaviors at the time that the support plan stated that the resident can not leave the facility unattended. A wanderguard was applied at the time of the admission and replaced numerous time but the resident removed the bracelet 4 times. All 4 of the wanderguard devices were not able to be located. The POA requested for the bracelet not to be reapplied due to incurring additional costs per the contract for the replacement transmitters. On 8/31/19, the resident was found by a bystander, not the police. A order was obtained from the CRNP on 8/31/19 for the staff to physically confirm that the resident is in the building and confirmation that the resident was physically seen is confirmed by the shift supervisor signing off every hour on the MAR (see attached order). In the facility, all of the exterior doors have a alarm that goes off every time any of the doors are opened. On 9/4/2019, a staff meeting was conducted and the staff was educated on elopement risk and response to door alarms (see attached attendance sheet). The resident's behaviors are now controlled with proper medication management and the resident continues to be followed by a psychiatrist and visiting nurse. The residents support plan was updated to reflect that he is no longer a elopement risk (see attached). The staff continues to be responsible for verifying hourly that the resident is in the facility and confirmation is verified by signing off on the MAR.

Elopement risk and response to door alarms will be discussed during Quality Management Meeting.

Jane E. Stubbins
adminstr
11/23/19