



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to HILLSIDE REST HOME, INC.
LEGAL ENTITY

To operate HILLSIDE PERSONAL CARE
NAME OF FACILITY OR AGENCY

Located at 1175 OLD WAYNESBORO PIKE, FAIRFIELD, PA 17320
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE ADDRESS OF SATELLITE SITE

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Personal Care Homes

To provide _____
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed 48
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller. (MAXIMUM CAPACITY)

Restrictions: _____

This certificate is granted in accordance with the Public Welfare Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from April 17, 2020 until April 17, 2021,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **348750**

Robert E. Robinson
ISSUING OFFICER

[Signature]
DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.



MAILING DATE: April 17, 2020

Ms. Cheryl Morgan
Administrator
Hillside Rest Home, Inc.
P.O. Box 552
Blue Ridge Summit, Pennsylvania 17214

RE: Hillside Personal Care
1175 Old Waynesboro Pike
Fairfield, Pennsylvania 17320
Certificate #: 348750

Dear Ms. Morgan:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspection on December 30, 2019, and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin Hancock", written in a cursive style.

Kevin Hancock
Deputy Secretary
Office of Long-term Living

Enclosure
License
Licensing Inspection Summary

Violation Report

Facility Information

Name: *HILLSIDE PERSONAL CARE*
Address: *1175 OLD WAYNESBORO PIKE,, FAIRFIELD, PA 17320*
County: *ADAMS* Region: *CENTRAL*

License Number: *34875*

Administrator

Name: *Cheryl Morgan* Phone: *7177942163* Email: *ISR2168@MSN.COM*

Legal Entity

Name: *HILLSIDE REST HOME, INC.*
Address: *PO BOX 552, BLUE RIDGE SUMMIT, PA, 17214*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *12/08/1978* Issued By: *LABOR AND INDUSTRY*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *44* Waking Staff: *33*

Inspection

Type: *Full* BHA Docket #: Notice: *Unannounced*
Reason: *Renewal, Complaint*

Inspection Dates and Department Representative

12/30/2019 - On-Site: Kellie Cargile, Dale Rosenblat

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* Residents Served: *44*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *17* Are 60 Years of Age or Older: *30*
Diagnosed with Mental Illness: *26* Diagnosed with Intellectual Disability: *18*
Have Mobility Need: *0* Have Physical Disability: *0*

64c - Annual Training

Regulations

2600.

64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff Person A, the home's administrator, completed only 22 hours of Department-approved training in training year May 1, 2018 to April 30, 2019.

Plan of Correction (POC)

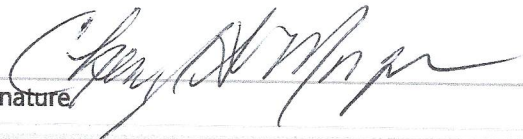
(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

An additional 2 hours will be completed during the current annual training period. Attached is the documentation for the additional 2 hours needed for the prior annual training year. (See attachment 64c)

On-going – The administrator will quarterly review status of training hours and schedule and complete 24 hours of trainings annually.

Staff training needs will be addressed at the home's next quality management review.

Legal Entity Representative

Signature 

Printed Name and Title Cheryl Morgan, Admin

Date 1/23/20

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The above plan of correction is approved as of 4/13/20 (Date)

Plan of correction implementation status as of 4/13/20 (Date)

Implemented

Not Implemented

The above plan of correction was approved by GE (Initials)

65b - Rights/Abuse 40 Hours

Regulations

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

Description of Violation

Staff Person B, hired 1/16/19, did not receive training in the home's emergency medical plan.

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.)

01/02/20 – Staff person hired 1/16/19 received training as per 65.b. (see attachment 65b (i) Training was completed on 1/16/19; however documentation and re-training completed 1/02/20

On-going – Administrator will review new hire training documentation within 2 weeks of hire for accuracy as per 65.b. Office manager will use the newly created checklist (see attachment 65b (ii)

Staff training needs will be addressed at the home's next quality management review.

Legal Entity Representative

Signature 

Cheryl Morgan, Admin/23/20
Printed Name and Title Date

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(Date)

Plan of correction implementation status as of 4/13/20
(Date)

The above plan of correction was approved by GE
(Initials)

Implemented
 Not Implemented

65f - Training Topics

Regulations

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

Description of Violation

Direct Care Staff Persons C and D did not receive training in medication self-administration during training year 2018 to 2019.

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.)

01/31/20 – All staff persons including staff persons C and D will receive training in medication self-administration as per “Medication Training – Getting it Right” transcript and Medication Self-Administration Assessment Checklist and proper medication storage. (see attached 65f (i))

On-going – All staff will be trained in medication self-administration and documented on the attached training documentation form as per regulation 2600.65.f (see attached 65f (ii)) by 2/27/20.

Staff training needs will be addressed at the home's next quality management review.

Legal Entity Representative


Signature

Cheryl Morgan, Admin 1/23/20
Printed Name and Title Date

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The above plan of correction was approved by	<u>GE</u> (Initials)	<input type="checkbox"/> Not Implemented	

132c - Fire Drill Records

Regulations

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The home's fire drill record included a fire drill on 12/30/19 at 12:30 pm. This date and time had not yet occurred when licensing representatives were on site.


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.)

01/14/20 - The error on the fire drill log was corrected as per the attached document from the alarm company (see attached 132c)

On-going - The building manager will correctly record all information on the fire drill log. The Administrator will review quarterly the fire drill log for accuracy.

Legal Entity Representative


Signature

Cheryl Morgan, Admin 1/23/20
Printed Name and Title Date

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132d - Evacuation

Regulations

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drill on 6/21/19 at 2:11 am, 41 residents were present in the home. However, only 39 residents were evacuated.

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.)

On 12/30/19 – Staff Person B that conducted the fire drill on 6/21/19 was educated to the proper way to record a fire drill. Staff person B had recorded the census number as the number of “Residents in home”, however on that day two residents were away from home

On-going – The Building Manager will review all fire drills for accuracy. Office staff were re-educated on the importance of regulation 2600.132d on 2/21/20.

Legal Entity Representative


Signature

Cheryl Morgan, Admin 1/23/20
Printed Name and Title Date

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132g - Fire Drills Days/Times

Regulations

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds fire drills near or on the last day of the month as evidenced by the following drills on 12/31/18, 1/31/19, 2/28/19, 3/30/19, 7/31/19, 8/30/19, 9/30/19 and 10/28/19.


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.)

Immediately – The Building Manager that conducts most fire drills was re-educated to the importance of regulation 2600.132g to insure residents and staff participate in all fire drills without prior knowledge to date and time of fire drills.

On-going – The Building Manager will conduct fire drills at random dates, days of the week, and times as to create the best outcome. January’s fire drill was conducted on 1/13/2020 @ 12:15pm (see attached 132g (ii)) on 2/21/20.

Legal Entity Representative


Signature

Cheryl Morgan; Admin
Printed Name and Title

1/23/20
Date

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141a 1-10 Medical Evaluation Information

Regulations

2600.

- 141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
 2. Medical diagnosis including physical or mental disabilities of the resident, if any.
 3. Medical information pertinent to diagnosis and treatment in case of an emergency.
 4. Special health or dietary needs of the resident.
 5. Allergies.
 6. Immunization history.
 7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
 8. Body positioning and movement stimulation for residents, if appropriate.
 9. Health status.
 10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1's medical evaluation, dated 10/7/19, does not include the resident's health status or cognitive functioning.

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.)

01/23/20 – Resident #1's DME was corrected to include the resident's health status and cognitive functioning. The Medical Care Coordinator was re-educated to the importance of regulation 2600.141.a (see attached 141a (i))

On-going - The Medical Care Coordinator will thoroughly review all paperwork received by doctors office before leaving the doctor office to make sure DME is complete, signed and dated. The Administrator will also review DME's within a week of the completion of the DME and document all reviews.

Legal Entity Representative


Signature

Cheryl Morgan Admin
Printed Name and Title

1/23/20
Date

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(Date) (Date)

The above plan of correction was approved by GE Implemented
(Initials) Not Implemented

183e - Storing Medications

Regulations

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 12/30/19, two loose pills were located in the home's medication cart; one round, white pill, identified as Metformin, and a red, triangular pill, identified as Xarelto.

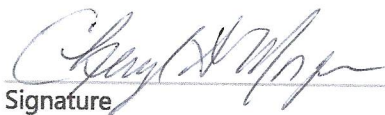
Plan of Correction (POC)

(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.)

Immediately – Pills were removed and disposed of as per policy. All Med Tech's were re-educated on caution of proper handling and disbursement of medications. All Med Tech's were re-educated to the policy on reviewing the cart on completion of med pass to assure no loose pills are in the cart or any surrounding areas.

On-Going – Med Tech's will continue to be reviewed by Medication Administration Trainer as for compliance with regulation 183e.

Legal Entity Representative


Signature

Cheryl Morgan; Admin
Printed Name and Title

1/23/20
Date

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(Date)

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(Initials)

Not Implemented

183f - Discontinued Medications

Regulations

2600.

183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

Nitroglycerin .4mg, prescribed to Resident #1 was located in the home's medication cart. The medication had expired on 9/2019,

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.)

Immediately – The medication was disposed of as per the home's policy. The Med Tech's were educated to reviewing the expiration date on the inside package as well as the pharmacy label.

On-Going - The Medication Administration Trainer will educated Med Tech's of how to review a medication for all potential expiration guidelines and re-ordering guidelines. 2/21/20

1. Pharmacy label expiration date
2. Manufacturer expiration date
3. Timed expiration after opening date – i.e.: insulin, eye drops etc.

Legal Entity Representative


Signature

Cheryl Morgan, Admin
Printed Name and Title

1/23/30
Date

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(Date)

Implemented

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(Initials)

Not Implemented

227g -Support Plan Signatures

Regulations

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #2 participated in the development of his support plan on 9/14/19. However, the resident did not sign the support plan.

Repeated Violation, 1/28/19.

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.)

Immediately – Resident #2 signed RASP on 12/30/19 (see attached 227g)

On-Going - The Medical Care Coordinator will obtain a signature on RASP at time of completion. If not able to do so there will be a note attached as to why signature was not obtained at the time and will obtain signature as soon as possible or RASP will be noted as to a refusal if appropriate. The Medical Care Coordinator will review RASP's quarterly for any changes or updates as needed. The Administrator will also review all RASP's within one week of completion for accuracy and will document the review.

Legal Entity Representative


Signature

Cheryl Morgan, Admin
Printed Name and Title

1/23/20
Date

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