Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

April 28, 2023

MON-VALE NON ACUTE CARE SERVICES INC

RE: THE RESIDENCE AT HILLTOP
210 ROUTE 837
MONONGAHELA, PA, 15063
LICENSE/COC#: 47488

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/07/2023, 03/08/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE RESIDENCE AT HILLTOP* **Licen e #**: *47488* **Licen e Expiration**: *04/01/2023*

Address: *210 ROUTE 837, MONONGAHELA, PA 15063*

County: *WASHINGTON* **Region**: *WESTERN*

Administrator

Name: **Phone**: **Email**

Legal Entity

Name: *MON-VALE NON ACUTE CARE SERVICES INC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *04/01/1998* **I ued By**: *L&I*

Type: *I 1* **Date**: *05/12/2017* **I ued By**: *Carrol Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *90* **Waking Staff**: *68*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal, Complaint* **Exit Conference Date**: *03/08/2023*

Inspection Dates and Department Representative

03/07/2023 On Site

03/08/2023 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *84* **Residents Served**: *73*

Secured Dementia Care Unit

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

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *72*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *17* **Have Physical Disability**: *1*

Inspections / Reviews

03/07/2023 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/22/2023*

Inspections / Reviews *(continued)*

03/22/2023 - POC Submission

Submitted By [redacted]
Date Submitted: *04/27/2023*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *03/28/2023*

03/28/2023 - POC Submission

Submitted By: [redacted]
Date Submitted: *04/27/2023*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *05/01/2023*

04/28/2023 - Document Submission

Submitted By: [redacted]
Date Submitted: *04/27/2023*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted on 9/23/16, requires a carbon monoxide alarm to be installed in close proximity of, but not less than 15 feet from any fossil fuel burning device or appliance. On 3/7/23, there was no carbon monoxide alarm installed in close proximity of the gas oven/range, located in the home's kitchen.

Plan of Correction ***Accept (- 03/28/2023)***

The Carbon Monoxide Alarm was replaced immediately on 3/7/23 in close proximity of, but not less than 15 feet from the gas oven/range located in our kitchen when found not present by the DHS inspector. It was removed when the area was being painted and not replaced immediately. The EVS director will check placement monthly. The monthly checks started beginning on 3/7/23, and will continue indefinitely every month during the Monthly Preventative Maintenance Checks. The batteries to the Carbon Monoxide detectors will be changed every March and November (twice a year.) See attached monthly PM of Carbon monoxide detector check list.

Licensee's Proposed Overall Completion Date: *03/22/2023*

Implemented - 04/28/2023)

121a - Unobstructed Egress

2. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 3/7/23 at 10:40am, the community room door was locked with a key lock. The community room door is labeled as an exit, because there is an exit door within the community room that leads to the outside.

Plan of Correction ***Directed - 03/28/2023)***

The DHS inspector found the door to the Community room , labeled as and exit locked. It was immediately unlocked, daily monitoring began- 3/7/23 on each shift to assure door to the community room is open and unlocked see attached monitoring sheet, The administrator educated current staff on regulation 2600. 121. a. that all stairways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed on 3/7/23. (DIRECTED: Documentation of the education shall be kept in accordance with 2600.65i. 3/28/23). All other staff were also in-serviced that all stairways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed on 3/8/23 and to ensure that the community room door is to be kept unlocked at all times. (DIRECTED: Documentation of the education shall be kept in accordance with 2600.65i. 3/28/23). A designated staff person on each shift will conduct a daily monitor until a nonlocking passageway door handle is installed on the Community Room Door . The maintenance technician on 3/22/23 installed a "KwickSet" interior non locking door knob on this door to the Community Room door. All other stairways, hallways, doorways, passageways and egress routes from rooms and from the building all have non locking doors or have push bars.

121a - Unobstructed Egress *(continued)*

Directed Completion Date: *03/28/2023*

Implemented [redacted] 04/28/2023)

132g - Fire Drills Days/Times

3. Requirements

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 schedules 3 staff persons on the midnight shift from approximately 10:00pm through 6:30am; however, the home has not conducted a fire drill with only 3 staff persons within the past year.

Plan of Correction ***Directed [redacted] - 03/28/2023)***

The EVS has develop and implemented a new system to ensure an unannounced fire drill is held at least once a month on different days of the week at different times of the day and night, and that fire drills will not be held when additional staff are present or not routinely held at times when resident attendance is low. The new system is that for the next 10 months the EVS has made a 10 month schedule of fire drills , to be conducted unannounced on different days of the week at different times of the day and night, and that fire drills will not be held when additional staff are present or not routinely held at times when resident attendance is low. The EVS had a unannounced fire drill on 3/22/23 at 12 midnight. Documentation of this system will be kept in the fire drill log. We will monitor the system to assure it is being followed at the monthly safety meetings, that are held on the third Wednesday of each month- This nformation will be documented on the monthly safety minutes. (DIRECTED: The monthly monitoring/review of the home's fire drill records shall begin with April, 2023 safety meeting. [redacted] 3/28/23).

DIRECTED: By 5/1/23: The home shall conduct an unannounced fire drill with only 3 staff persons. Documentation of the fire drill shall be kept in accordance with 2600.132c. [redacted] 3/28/23).

Directed Completion Date: *05/01/2023*

Implemented [redacted] - 04/28/2023)

141b1 - Annual Medical Evaluation

4. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #1's most recent medical evaluation, dated [redacted]/22, does not include resident #1's height. This section of the form is blank.

REPEAT VIOLATION: 2/8/2022, et. al.

141b1 - Annual Medical Evaluation (continued)

Plan of Correction ***Directed (LM 03/28/2023)***

Resident #1 height was added to the DME by the Admin-LPN this was done on 23. The administrator did educated the DON/designee-(support plan coordinator) on 3/8/23 on regulation2600.141.b.1. by going over the nformation in the RCG and to reinforce that all information including height, is included. The administrator / DON/designee began to audit all present DME's and annual DME's to be reviewed for completeness by 4/28/23. An ongoing audit will be done by the DON/ 1st check then the Support Plan Coordinator/designee 2nd check on all medical evaluations new and annuals the audit will be filled out on the "DME audit Tool". The POC and monitoring results of the "DME audit tool" will be reviewed and evaluated by the administrator /DON and SPC at the monthly QA meeting. (attached is audit tool) This tool will be kept in the QA notebook. The QA meetings are held the last Thursday of every month. (DIRECTED: The monthly review of the audit tool shall begin with the April, 2023 quality management meeting. Documentation of the quality management reviews shall be kept. LM 3/28/23).

Directed Completion Date: *05/01/2023*

Implemented 04/28/2023)

224a - Preadmission Screen Form

5. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #2's preadmission screening form, dated 23, does not indicate the resident's level of supervision needs. This section of the form is blank.

Plan of Correction ***Directed 03/28/2023)***

Resident # 2 preadmission screen was updated on 3/8/23. Administrator educated DON/designee (support plan coordinator) on 3/8/23 on regulation 2600 224.a. By going over information in the RCG to reinforce that a determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home. All preadmissions screens will be double checked by the DON/SPC designees to assure completeness, The check system began on 3/8/23 and all checked preadmission screens will be checked and initialed in the lower right corner for completeness by 4/28/23. All new preadmission screens will be doubled checked by the Administrator/DON/Support Plan Coordinator at the monthly QA audit meetings and will be documented on the Preadmission screen/DME/RASP audit tool for completeness and accuracy. This will be an ongoing audit. (attached is audit tool) This tool will be kept n the QA notebook. The QA meetings are held the last Thursday of every month. (DIRECTED: The monthly review of the audit tool shall begin with the April, 2023 quality management meeting. Documentation of the quality management reviews shall be kept. LM 3/28/23).

Directed Completion Date: *05/01/2023*

Implemented (- 04/28/2023)

225a - Assessment 15 Days

6. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

On [redacted]/23, resident #2 was prescribed a mechanical soft diet; however, this is not indicated on resident #2's assessment, dated [redacted]23.

Plan of Correction ***Directed [redacted] - 03/28/2023)***

The administrator educated the DON/designee-(support plan coordinator 3/8/23 on regulation 2600. 225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment. And immediately updating the residents assessment when changes are made such as a change in diet. Resident #2 assessment was updated with an addendum by the support plan coordinator on 3/8/23 with mechanical soft diet and her initials and date. All RASP's are being reviewed for accuracy by the administrator/DON/designee (SPC) this audit will be done by 4/28/23. An ongoing audit of all new RASPS will be done at the monthly QA meetings RASPS will be doubled checked by the Administrator/DON/Support Plan Coordinator and will be documented on the Preadmission screen/DME/RASP audit tool for completeness and accuracy. This will be an ongoing audit. (attached is audit tool) This tool will be kept in the QA notebook. The QA meetings are held the last Thursdays of the month. (DIRECTED: The monthly review of the audit tool shall begin with the April, 2023 quality management meeting. Documentation of the quality management reviews shall be kept. LM 3/28/23).

Directed Completion Date: *05/01/2023*

Implemented ([redacted] - 04/28/2023)