pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing Date: June 30, 2023

[redacted]
The Villages of Hilltop Heights
[redacted]

RE: The Villages at Hilltop Heights
100 Woodmont Road
Johnstown, Pennsylvania 15905
Certificate #: 338660

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspections on May 5, 2023 of the above facility, we have found that your facility is in substantial compliance with the regulations, set forth in 55 pa. Code Ch. 2800 (relating to Assisted Living Residence).

In accordance with 55 Pa.Code § 2800.11(b) (relating to procedural requirements for licensure or approval of personal care homes) a re-inspection of your newly licensed facility will be conducted within 3 months of the effective date of this license. Complete compliance with all applicable regulations is required in order to maintain your license.

Your NEW license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

June 23, 2023

[redacted]
The Villages of Hilltop Heights
[redacted]

RE: THE VILLAGE OF HILLTOP HEIGHTS
100 WOODMONT ST
JOHNSTOWN, PA, 15905
LICENSE/COC#: 33866

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/05/2023, 06/01/2023 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,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE VILLAGE OF HILLTOP HEIGHTS* **Licen e #**: *33866* **Licen e Expiration**:

Address: *100 WOODMONT ST, JOHNSTOWN, PA 15905*

County: *CAMBRIA* **Region**: *CENTRAL*

Administrator

Name: [redacted] **Phone** [redacted] **Email**: [redacted]

Legal Entity

Name: *The Villages of Hilltop Heights*

Address: [redacted]

Phone: **Email** [redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *76* **Waking Staff**: *57*

Inspection Information

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

Reason: *Complaint, Change Legal Entity* **Exit Conference Date**: *06/01/2023*

Inspection Dates and Department Representative

05/05/2023 On Site [redacted]

06/01/2023 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: **Residents Served**: *74*

Special Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *12* **Are 60 Years of Age or Older**: *72*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *2*

Have Mobility Need: *2* **Have Physical Disability**: *3*

Inspections / Reviews

05/05/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/16/2023*

06/20/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/23/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/28/2023*

Inspections / Reviews *(continued)*

06/23/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/23/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/30/2023*

06/23/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/23/2023*

Reviewer: [redacted] **Follow-Up Type:** *Not Required*

15a Resident abuse report

1. Requirements

2800.
15.a. The residence shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 3/10/23, Resident #2 was hit and pushed by another resident. The residence did not complete the Act 13 form and send it to the Area Agency on Aging.

Plan of Correction ***Directed [redacted] - 06/23/2023)***

On 6/21/2023 the director of resident services contacted AAA and completed an Act 13 form regarding the incident on 3/10/2023. Moving forward, the administrator or designee will ensure that all suspected abuse cases are handled promptly and completely. Education to be provided to staff responsible for completing abuse reports to ensure these incidents are reported correctly and in accordance with regulations. Education began on 6/21/2023 and will be completed no later than 6/27/2023.

Directed - 6/23/23

- The Administrator will review the home's policies and procedures by 6/29/23 addressing prevention, reporting, notification, investigation and management of reportables and update if needed. All reports will be reviewed at the Quality Management meetings, with the next being held on 6/29/23.
- The Administrator will review the RCG on abuse and reporting suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act by 6/29/23. If the home is unsure an incident is abuse, they will review the RCG or call the Department's Hotline to inquire.

Directed Completion Date: *06/29/2023*

Implemented [redacted] - 06/23/2023)

16c Incident reporting

2. Requirements

2800.
16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

On 3/10/23, Resident #2 was hit and pushed by another resident. The residence did not report this incident to the Department.

Plan of Correction ***Directed [redacted] - 06/23/2023)***

On 6/21/2023 the director of resident services submitted an incident report, act 13, and supporting documentation from the incident on 3/10/2023, to the department. Moving forward, the Administrator or designee will ensure all suspected abuse cases are handled promptly and completely. Education to be provided to staff responsible for submitting incident reports to ensure the facility does not fail to report incidents that need to be reported. Education began on 6/21/2023 and will be completed no later than 6/27/2023.

Directed - 6/23/23

16c Incident reporting (continued)

- All of the home's staff will be re-educated by 6/29/23 on abuse, to include the home's abuse policies, as well as reporting guidelines and time frames
- The Administrator will review the home's policies and procedures by 6/29/23 addressing prevention, reporting, notification, investigation and management of reportables and update if needed.
- The Administrator will review the RCG on abuse and reporting suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act by 6/29/23. If the home is unsure an incident is abuse, they will review the RCG or call the Department's Hotline to inquire.

Directed Completion Date: *06/29/2023*

Implemented [redacted] - 06/23/2023)

60a Staffing/support plan needs

3. Requirements

2800.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident s assessment and support plan. Residence staff or service providers who provide services to the residents in the residence shall meet the applicable professional licensure requirements.

Description of Violation

While the residence's schedule meets the required hours for waking hours, the first shift is not staffed adequately to meet the residents' needs, based upon resident and staff interviews, as well as the needs and acuity level of current residents.

Plan of Correction ***Directed [redacted] - 06/23/2023)***

Since May, the facility has hired multiple staff members to assist in the care of residents. At this time four staff members have been hired to assist in caring for the residents. The four staff members started on [redacted]. In addition to hiring more staff, the facility has made a plan to assist with meeting the needs of residents. While the recruitment process continues, the facility's licensed staff will provide extra assistance when needed to help with caring for residents. This extra assistance includes providing direct care, passing medications, assistance during mealtimes, and anything else that can be done to assist DCS during times of need. Finally, the Administrator, or designee, will continue to review resident acuity levels, quarterly and as needed, to ensure residents who require increased levels of care are having their needs met. Any resident identified as requiring a level of care higher than the facility can meet will be discussed at quality assurance meetings to determine if seeking a higher level of care is necessary.

Directed - 6/23/23
- The administrator or designee will review the resident acuity levels and resident needs to be addressed at all QM meetings, with the next meeting to be hold on 6/29/23.
- Beginning 6/26/23, the administrator or designee will review the schedule weekly to ensure staffing meets resident needs. If staff call off or leave early, the home will ensure residents needs are met.

60a Staffing/support plan needs *(continued)*

Directed Completion Date: *06/29/2023*

Implemented (- 06/23/2023)

82c Locked poisons

4. Requirements

2800.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the residence are able to safely use or avoid poisonous materials.

Description of Violation

On 5/5/23 at approximately 1:30 pm, denture cleanser tabs, which contain a manufacturer's label that states, "In case of accidental ingestion, seek professional assistance or contact the Poison Control Center (1-800-222-1222) right away," were found in the vanity of Resident # 1's bathroom. There are at least 3 residents with dementia who wander on this unit and these residents are not safe around poisons.

Plan of Correction ***Directed - 06/23/2023)***

After the initial inspection all poisonous materials that were stored in resident rooms, were locked in bathroom cabinets to prevent accidental exposure to those residents that cannot safely avoid poisonous material. The administrator or designee has since started providing staff education to ensure staff understand the importance of keeping these items locked. Education began on 6/21/23 and will be completed no later than 6/27/23. Moving forward the Administrator or designee has begun weekly audits of rooms starting on 6/12/23 x 4 weeks, and will complete monthly audits x 3 months once weekly audits are completed. All audits will be discussed at the facility's quality assurance meetings to ensure compliance.

Directed - 6/23/23
- By 6/26/23, all poisonous materials in resident rooms will have been removed for residents who are assessed as not safely able to be safe around poisons or will be locked in resident bathroom cabinets for those who are safe around poisons.
- The home's education will include knowledge on what constitutes a poisonous material, example the contact poison control label on the product.
- All audits will be discussed at each QM meeting, with the next meeting being held on 6/29/23.
- By 6/29/23, the home will educate all residents who are assessed to be safe around poisons, the importance of ocking these items, as well as reminders as needed. These residents will be assessed annually, or more frequently if there is a significant change, to determine if the resident remains to be safe around poisons.

Directed Completion Date: *06/29/2023*

Implemented - 06/23/2023)

85b Infestation

5. Requirements

2800.
85.b. There may be no evidence of infestation of insects or rodents in the residence.

85b Infestation *(continued)*

Description of Violation

On 5/5/23, at approximately 1:00 pm, Resident #3 stated they had seen at least 2 mice in their room in the past 2 weeks and that mice droppings were in the top 2 dresser drawers. There was a large amount of mouse droppings on top, in between and under clothing, as well as pieces of chewed up paper.

Plan of Correction ***Directed [redacted] - 06/23/2023)***

mmediately upon noticing mouse droppings in a room on 6/12/23, the facility housekeeping department deep cleaned the room, including in dresser drawers. During the cleaning, maintenance inspected the room for live mice, sealed any possible entry/exit, and placed nonpoisonous traps where residents could not access. As of 6/21/2023 no evidence of mice has been observed. The facility has a contracted pest company that provides monthly service and was in the facility last on 6/7/2023. Moving forward the Administrator or designee will complete weekly audits of rooms x 4 weeks, and then monthly audits x 3 months to ensure the residence is pest free. Findings of audits will be reported at monthly quality assurance meetings.

Directed - 6/23/23
- The home shall review findings at the each Quality Management meeting, with the next meeting being held on 6/29/23.
- Beginning 6/12/23, administrator or designee will complete weekly audits of rooms x4 weeks, and then monthly audits x3 months to ensure the residence is pest free.
- All staff will be educated on reporting any evidence of infestation of pests to management, to be completed no later than 6/29/23.
- By 6/29/23, the home shall review (or create if no policy is in place) pest control policies to ensure any reports of pests are dealt with timely, that the home is kept pest free.

Directed Completion Date: *06/29/2023*

Implemented [redacted] - 06/23/2023)

105g Dryer lint removal

6. Requirements

2800.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer s instructions.

Description of Violation

On 5/5/23 at approximately 10:15 am, 2 layers of lint accumulation was found in the lint trap of the dryer on the first floor. There were no clothes in the dryer at the time and the dryer was cool to the touch.

Plan of Correction ***Directed [redacted] - 06/23/2023)***

Upon notification of violation, the Administrator or designee designed and posted signs reminding staff and residents to clean the dryer lint traps after each use. On 6/21/23 staff education began on the removal of lint from the dryer trap after each use. Education will be completed no later than 6/27/2023. The administrator or designee have also begun weekly audits of dryers, starting on 6/12/2023 x 4 weeks. Once weekly audits are completed the administrator or designee will complete monthly audits x 3 months. Once monthly audits are completed random checks will be

105g Dryer lint removal (continued)

completed by the Administrator or designee to ensure compliance with this regulation. Audits and findings will be reported at the facility's quality assurance meetings.

Directed - 6/23/23
- Audits will be discussed at the next Quality Management meeting to be held on 6/29/23.

Directed Completion Date: *06/29/2023*

Implemented [redacted] - 06/23/2023)

183b Medications and syringes locked

7. Requirements

2800.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's living unit.

Description of Violation

On 5/5/23 at approximately 1:45 pm, the prescription medication, diclofenac 1% gel was unlocked, unattended, and accessible in Resident #1's bathroom.

Plan of Correction ***Directed [redacted] - 06/23/2023)***

After initial inspection, all prescription medications that were stored in rooms were locked in the resident's bathroom cabinets. Administrator or designee will provide education to staff regarding keeping medications locked in the cabinet or med cart while not in use. This education was started on 6/21/23 and will be completed no later than 6/27/2023. Administrator or designee has also began auditing rooms for unlocked medications. Weekly audits began on 6/12/23 and will run for 4 weeks, after weekly audits are completed, the administrator or designee will complete monthly audits x 3 months. Random checks will be completed after the scheduled audits are completed. All audits and findings will be discussed at the facility's quality assurance meetings.

Directed - 6/23/23
- By 6/26/23, all medications in resident rooms will have been removed for residents who are assessed as able to self medicate or will be locked in resident bathroom cabinets for those who are able to self medicate.
- All audits will be discussed at each QM meeting, with the next meeting being held on 6/29/23.
- By 6/29/23, the home will educate all residents who are assessed to be able to self medicate, the importance of locking these items, as well as reminders as needed. These residents will be assessed annually, or more frequently if there is a significant change, to determine if the resident remains able to self medicate.

Directed Completion Date: *06/22/2023*

Implemented [redacted] - 06/23/2023)