



Certified End Page

HILLTOP HEALTHCARE AND REHABILITATION CENTER

STATE LICENSE NUMBER: 341902

SURVEY EXIT DATE: 01/15/2025

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, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395241	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025
NAME OF PROVIDER OR SUPPLIER: HILLTOP HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 700 SOUTH CAYUGA AVENUE ALTOONA, PA 16602		
STATE LICENSE NUMBER: 341902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 341902 Component 01 Main Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on January 15, 2025, it was determined that Hilltop Healthcare and Rehabilitation Center was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a one-story, Type V (000), unprotected wood frame building, with a basement, that is fully sprinklered.</p>	K 0000		

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)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395241	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025
NAME OF PROVIDER OR SUPPLIER: HILLTOP HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 700 SOUTH CAYUGA AVENUE ALTOONA, PA 16602		
STATE LICENSE NUMBER: 341902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
K 0321 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain hazardous area enclosures in one instance, affecting one of eight smoke compartments. Findings include: 1. Observation on January 15, 2025, at 11:20 a.m., revealed the door to the storage closet in the Rehabilitation Room failed to latch due to tape being placed on the striker plate. Interview with the Facility Administrator and Assistant Maintenance Director on January 15, 2025, at 1:00 p.m., confirmed the listed hazardous area enclosure deficiencies.	K 0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395241	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025
NAME OF PROVIDER OR SUPPLIER: HILLTOP HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 700 SOUTH CAYUGA AVENUE ALTOONA, PA 16602		
STATE LICENSE NUMBER: 341902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
K 0324 SS=E	<p>NFPA 101 Cooking Facilities</p> <p>Cooking Facilities</p> <p>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:</p> <ul style="list-style-type: none"> * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0324	<p>Semiannual kitchen fire suppression testing was located and added to the life safety binder. The cleaning of the kitchen exhaust Hood/Duct was scheduled for completion on 1/27/2025</p> <p>Review of life safety binder will be completed monthly by maintenance director/designee to ensure all needed paperwork is easily accessible. The facility obtained contracted services to ensure Kitchen exhaust hood/duct cleaning is completed as required.</p> <p>Semiannual cleaning will be monitored by facility maintenance director/designee to ensure completion and brought to the facility's Quality assurance committee meeting for confirmation and review.</p> <p>Date of compliance 2/28/2025</p>	<p>Completion Date: 02/28/2025</p> <p>Status: APPROVED</p> <p>Date: 01/24/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395241	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025	
NAME OF PROVIDER OR SUPPLIER: HILLTOP HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 341902		STREET ADDRESS, CITY, STATE, ZIP CODE: 700 SOUTH CAYUGA AVENUE ALTOONA, PA 16602		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
K 0324 SS=E	Continued from page 4 Based on documentation review, observation, and interview, it was determined the facility failed to maintain cooking facilities in two instances, affecting one of eight smoke compartments. Findings include: 1. Observation and document review on January 15, 2025, revealed the facility lacked documentation for the following: a) 9:20 a.m., semiannual Kitchen fire suppression Testing/Maintenance for second half of 2024; b) 9:25 a.m., semiannual Kitchen exhaust Hood/Duct cleanings for second half of 2024. Interview with the Facility Administrator and Assistant Maintenance Director on January 15, 2025, at 1:00 p.m., confirmed the kitchen fire suppression system and hood deficiencies.	K 0324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395241	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025	
NAME OF PROVIDER OR SUPPLIER: HILLTOP HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 341902		STREET ADDRESS, CITY, STATE, ZIP CODE: 700 SOUTH CAYUGA AVENUE ALTOONA, PA 16602		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
K 0324 SS=E	Continued from page 5	K 0324		
K 0918 SS=F	<p>NFPA 101 Electrical Systems - Essential Electric System</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing</p> <p>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p>	K 0918	<p>1. Documentation for the emergency generator annual preventive maintenance was found and added to the life safety binder.</p> <p>2. review of life safety binder will be completed monthly by maintenance director/designee to ensure all needed paperwork is available.</p> <p>3. Maintenance Director will bring results of monthly audit to the facility's Quality Assurance Committee for review</p>	<p>Completion Date: 02/28/2025</p> <p>Status: APPROVED</p> <p>Date: 01/22/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395241	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: HILLTOP HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 341902	STREET ADDRESS, CITY, STATE, ZIP CODE: 700 SOUTH CAYUGA AVENUE ALTOONA, PA 16602
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
K 0918 SS=F	Continued from page 6 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395241	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025
NAME OF PROVIDER OR SUPPLIER: HILLTOP HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 700 SOUTH CAYUGA AVENUE ALTOONA, PA 16602		
STATE LICENSE NUMBER: 341902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
K 0918 SS=F	Continued from page 7 Based on document review and interview, it was determined the facility lacked documentation for emergency generator annual testing for the past 12 months, affecting the entire facility. Findings include: 1. Document review on January 15, 2025, at 9:35 a.m., revealed the facility could not provide emergency generator documentation for the annual preventative maintenance/testing for 2024. Interview with the Facilities Administrator and Assistant Maintenance Director on January 15, 2025, at 1:00 p.m., confirmed the facility lacked documentation for the required maintenance/testing of the emergency generator, at the time of the survey.	K 0918		



Certified End Page

HILLTOP HEALTHCARE AND REHABILITATION CENTER

STATE LICENSE NUMBER: 341902

SURVEY EXIT DATE: 01/15/2025

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, 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