

Department of Human Services
Bureau of Human Service Licensing

February 2, 2022

[REDACTED], OWNER
[REDACTED]
[REDACTED]

RE: PINE VIEW PERSONAL CARE
FACILITY
1113 PINE VIEW LANE
VANDERGRIFT, PA, 15690
LICENSE/CO# : 42669

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/19/2021, 07/20/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[REDACTED]

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *PINE VIEW PERSONAL CARE FACILITY* License #: *42669* License Expiration: *10/30/2021*
Address: *1113 PINE VIEW LANE, VANDERGRIFT, PA 15690*
County: *ARMSTRONG* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

[REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *04/14/1999* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *19* Waking Staff: *14*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal* Exit Conference Date: *07/20/2021*

Inspection Dates and Department Representative

07/19/2021 - On-Site: [REDACTED]

07/20/2021 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *28* Residents Served: *18*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *3* Are 60 Years of Age or Older: *17*
Diagnosed with Mental Illness: *3* Diagnosed with Intellectual Disability: *2*
Have Mobility Need: *1* Have Physical Disability: *0*

Inspections / Reviews

07/19/2021 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/12/2021*

Inspections / Reviews (*continued*)

09/22/2021 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *09/27/2021*

10/05/2021 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *10/11/2021*

02/02/2022 - Document Submission

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

85a - Sanitary Conditions

1. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

There was approximately 1/2 inch of reddish, brownish liquid on the tray in the bottom of the double door stainless steel refrigerator in the kitchen. There were nine 1 gallon jugs of milk on the tray. Also, the shelves in this refrigerator were covered in rust which was flaking off on both the top and bottom of the shelves.

Plan of Correction

Accept

85.A Liquid was cleaned up immediately while inspector was here. The jugs were wiped clean also. Owner met with the cooks discussed proper procedures in the kitchen and the importance of following procedures. All parties understood. Shelving has been removed and recovered and put back in place.

Document Submission

Implemented

Shelving is replaced and clean

101j5 - Bedside Table/Shelf

1. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
5. A bedside table or a shelf.

Description of Violation

There is no bedside table or shelf in resident #1's bedroom.

Plan of Correction

Accept

101.j The table was replaced immediately while inspector was present. Resident A is a hospice resident and the table was moved to assist in care. We replaced the table and did explain to all staff at the meeting this regulation and explained a side table is a requirement and not to move table again.

Document Submission

Implemented

see attached

101j7 - Lighting/Operable Lamp

1. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident #2 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction

Accept

101.j The light was replaced while inspector was present. As explained resident 2 removed the light not wanting it there. Admin spoke to the resident explained we are required to have it there, [redacted] understood and agreed to leave

101j7 - Lighting/Operable Lamp (continued)

it there. We also discussed this regulation at the staff meeting so everyone was aware.

Document Submission**Implemented**

see attached

103f - Refrigerator/Freezer Temps**1. Requirements**

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 7/19/2021 at 10:53 a.m., the temperature in the upright freezer in the kitchen was 8 degrees Fahrenheit.

In addition, at 10:54 a.m., the temperature in the double door stainless refrigerator in the kitchen was 50 degrees Fahrenheit.

There were no thermometers in the two small white chest freezers and one large white chest freezer outside of the kitchen in the home's basement.

Plan of Correction**Accept**

103.f Owner purchased new thermometers and placed in all freezers Owner contacted refrigeration repairman and the refrigeration was repaired Owner explained to cooks to check temps daily on their shifts / owner also asked maintenance to check these thermometers daily. In addition to this cooks and maintenance will have a form to sign off that temps are checked daily. A copy of the repair bill will also be attached when requested.

Document Submission**Implemented**

see attached

103g - Storing Food**1. Requirements**

2600.

103.g. Food shall be stored in closed or sealed containers.

Description of Violation

There was a package of American cheese, with approximately 75 slices, in double door stainless refrigerator in the kitchen that was open and unsealed.

In addition, the following dry food in the kitchen cupboard was open and unsealed:

One clear bag of spring noodles, approximately ¼ full

One bag of instant mashed potatoes flakes, approximately 1/5 full

One 12 ounce bag of chocolate chips, approximately ½ full

One bag of raspberry gelatin mix, approximately 1/10 full

One bag of lime gelatin mix, approximately 1/10 full

Plan of Correction**Accept**

103.g All food was put in sealed plastic bags while inspector was present. In addition owner went over proper food storage with the cooks and all staff. In addition to having a discussion with staff this regulation will be put into

103g - Storing Food (continued)

writing and all staff members will sign off on it. This documentation will be kept in a file with the administrator. A copy can be sent if requested. This will now become a practice by administrator to show documentation of all regulations discussed.

Document Submission**Implemented**

see attachment

130d - Interconnected Detectors**1. Requirements**

2600.

130.d. If the home serves nine or more residents, there shall be at least one smoke detector on each floor interconnected and audible throughout the home or an automatic fire alarm system that is interconnected and audible throughout the home.

Description of Violation

On 7/19/2021, the home served 18 residents. There is not an interconnected and audible smoke detector on the 3rd floor of the home.

Plan of Correction**Accept**

130.d Owner has been in conversations with our fire chief and fire expert. They have the equipment ordered and it will be installed as soon as it arrives. Due to covid shipping is behind Owner has been in touch and has documentation to show that he has been talking with them. We are hoping that in the next two weeks we will have this completed and will send a completed task to you

Document Submission**Implemented**

All paperwork discussed and signed by staff for requirements. Detectors are in the process delayed shipping see attachment

96a - First Aid Kit**1. Requirements**

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the resident kitchen/dining room was missing adhesive tape, scissors, and tweezers.

Repeat Violation: 5/7/2019

Plan of Correction**Accept**

96.A The tape, scissors, and tweezers were put back in the first aide kit while the inspector was present. A staff member had used them and had them in the med room- did not return after use. All 3 items were replaced. At staff meeting it was explained to all staff these things need replaced immediately after use. In addition to the staff meeting and moving forward this regulation will also be put in writing and each staff person will sign off on it to show understanding. This documentation and any other future discussions will also be signed off on and all documentation will be kept by admin. A new form discussing this will be completed by all staff.

Document Submission**Implemented**

see attached

121a - Unobstructed Egress

1. 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 7/19/2021 at 9:52 a.m., a wooden dining room chair blocked egress from the home's resident kitchen/dining room emergency exit.

Also, the emergency exit door at bottom of landing was jammed and difficult to open.

In addition, the emergency exit door nearest resident #3's room was jammed and difficult to open.

Repeat Violation: 5/7/2019

Plan of Correction

Accept

The chair was removed immediately Entire room was rearranged so a chair will not accidentally be put there again. All staff were informed of this requirement at the staff meeting. The maintenance man sprayed lubricant on all exit doors and also adjusted the bottom plate ton the door frames to aide in opening. He will also check regularly with the changes in weather. A form for our maintenance man to complete that these exits are checked weekly will be signed off on to show that doors are opening without difficulty. A form showing that all staff were explained that nothing can block a fire exit , (as discussed), will also be signed off on to show documentation of understanding by all staff.

Document Submission

Implemented

see attached