Department of Human Services
Bureau of Human Service Licensing

June 7, 2022

[redacted], OWNER
[redacted]

RE: THE RIDGE AT HERITAGE MEADOWS
1126 ROSS AVENUE
FORD CITY, PA, 16226
LICENSE/COC#: 45289

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/15/2022, 03/16/2022 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: *THE RIDGE AT HERITAGE MEADOWS* **License #:** *45289* **License Expiration:** *12/14/2022*

Address: *1126 ROSS AVENUE, FORD CITY, PA 16226*

County: *ARMSTRONG* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *THE RIDGE AT HERITAGE MEADOWS LLC*

Address: *115 HERITAGE MEADOWS LANE, WORTHINGTON, PA, 16262*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *04/07/2000* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *30* **Waking Staff:** *23*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *03/16/2022*

Inspection Dates and Department Representative

03/15/2022 - On-Site: [redacted]

03/16/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *45* **Residents Served:** *23*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *2* **Are 60 Years of Age or Older:** *23*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *7* **Have Physical Disability:** *0*

Inspections / Reviews

03/15/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/11/2022*

04/19/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/22/2022*

06/07/2022 - Document Submission

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 3/15/22, the home's current license inspection summary, dated 1/6/22, was not posted in a conspicuous and public place in the home. The most current license inspection summary posted was dated 8/21/19.

Plan of Correction ***Accept***

Description of Violation- on 3/15/22 the home's current license inspection summary, dated 1/6/22, was not posted in a conspicuous and public place in the home.
The home's most recent inspection summary was located on Administrator Graham's desk, as she had a list of paperwork that she was updating and reviewing, which included re-building the current binder and updating.

Plan of Correction: The inspection summary dated 1/6/22 was copied and posted in a binder in the foyer on the date of 3/15/22 during the inspection by [redacted], Administrator-in-training.
This binder will be checked weekly for compliance for 1 month, then 1 time monthly there after by [redacted] or a designated member of the facility.

See attached
1. Picture of binder located in entryway of upper level
2. Picture of most recent licensing inspection dated 1/6/22
3. Log Sheet to be completed weekly x 1 month and monthly there after
Completion Date: *03/15/2022*

Document Submission ***Implemented***

see attached updated log sheet

25a - Written Contract and Review

1. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

On 3/15/22, resident #1, was originally admitted into the home on [redacted]. On 12/14/21 there was new ownership of the home. Resident #1 did not have a new resident-home contract completed.

Plan of Correction ***Accept***

Plan of correction: A contract was submitted to Resident #1 rep payee and has not be returned. Multiple attempts to reach rep payee have been unsuccessful and as a result, the facility is exploring the ability to become rep payee for said resident to avoid potential delays in the future.
New copy of contract made and resident signed in appropriate locations on 3/18/22 and completed by resident and Administrator [redacted].
An audit sheet was developed for all current contracts and new contracts that will be coming in the future. This was completed by 4/11/2022 for all current contracts by Administrator [redacted].
Audit will be done monthly by a member of management to assess for all required documentation.

25a - Written Contract and Review (continued)

See Attached:
1. Completed contract for Resident #1 - Please be advised, due to size of file, SansWriteX will not accept. Completed signature pages of contract attached
2. Audit Tool for Resident Contract Chart

Completion Date: *04/11/2022*

Document Submission ***Implemented***

completed

54a - Direct Care Staff

1. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

On 3/16/22, direct care staff person A, hired, [redacted], did not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept***

Plan of correction: Direct Care Person A did have a GED, however, [redacted] completed this program while [redacted] was incarcerated and had been attempting to obtain a copy of [redacted] GED.
In the meantime, [redacted] signed a statement verifying that [redacted] did have appropriate education to complete [redacted] job duty requirements.
On 3/16/22 a copy of GED was obtained for staff person A by contacting 2 different correctional facilities to locate the appropriate department that could research and find Direct Care Person A's GED, which they then emailed to a member of management and was then provided to the Department of Human Services via email to surveyor [redacted]
An audit sheet was developed to place in all staff files to ensure all mandatory information is contained.
Audit completed 4/11/22 by Administrator [redacted].
This audit will be completed monthly by a member of management.

See Attached:
1. Signed verification of educational requirements
2. GED obtained through correctional facility
3. TNA certification obtained through accredited program
4. Audit Tool for Staff Employment Regulations

Completion Date: *04/08/2022*

Document Submission ***Implemented***

see attached audit tools

82a - Poisonous Materials

1. Requirements

82a - Poisonous Materials *(continued)*

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 3/15/22, there was an one gallon container of a green liquid sitting on the bottom shelf of a closet by the medication closet on the lower level of the home that did not have a label that was legible. The staff indicated the liquid was a drain cleaner.

Plan of Correction ***Accept***

Plan of Correction: on 3/15/22 during the inspections, the green liquid was immediately removed from the closet and disposed of appropriately by [redacted], Administrator-In-Training.
A log sheet was created that combines regulation 82.a and 82.b. that will be completed weekly by [redacted], or a designated member of the facility. Education explaining regulation and how it applies to the home was developed by Administrator [redacted] and given to staff to read.

See Attached:
1. Poisonous Material Checklist for Regulation 82a
2. Staff Education

Completion Date: *03/24/2022*

Document Submission ***Implemented***

see attached

82b - Poisonous Material Storage

1. Requirements

2600.
82.b. Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

Description of Violation

On 3/15/22, there were seven, 48 ounce bottles of prune juice stored on the same lower shelf with an one gallon container of drain cleaner in a closet by the medication closet on the lower level of the home.

Plan of Correction ***Accept***

Plan of Correction: Drain cleaner was immediately removed from closet on 3/15/22 by [redacted], Administrator-In-Training, and disposed of.
A log sheet created that combines regulation 82.a and 82.b. will be completed weekly by [redacted], or a designated member of the facility.
Education explaining regulation and how it applies to the home was developed by Administrator [redacted] and given to staff to read.
A sign was posted on the door to indicate that no chemicals are to be stored there.

See Attached:

82b - Poisonous Material Storage (continued)

1. Poisonous Material Checklist for Regulation 82b
2. Staff Education
3. Sign posted on closet door

Completion Date: *03/24/2022*

Document Submission ***Implemented***

see attached

88a - Surfaces

1. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 3/15/22, the fire exit door by bedroom #7 on the upper level of the home has rust along the entire length of the lower edge of door with an approximate 1 inch by 1 inch hole in the right lower corner of the door.

Plan of Correction ***Accept***

Plan of Correction: The home has a current list of larger ticket items that need replaced, including the door. This door was already on a list of repairs that needed completed. However, due to the cost and availability of supplies, the facility has had financial constraints, making it difficult to be able to afford these higher priced repairs.
A replacement door was able to be ordered on 3/31/22; the door was delivered 4/7/22.
Installation is scheduled to be completed by 4/22/22 by a contracted service.
A log sheet was developed by Administrator [redacted] to check condition of exterior doors to be completed monthly by a designated member of the facility.
Staff education was provided to teach staff on routinely making observations in regards to this regulation and reporting any needs to facility management immediately

See Attached:
1. Receipt of purchase for door
2. Log sheet
3. Staff Education

Completion Date: *04/22/2022*

Document Submission ***Implemented***

scheduled to be completed

91 - Telephone Numbers

1. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

91 - Telephone Numbers *(continued)*

Description of Violation

On 3/15/22, there were no emergency telephone numbers to include the nearest hospital and fire department on or by the telephones in the upper level entrance area by the reception window and by the reception/administrator's office door.

Plan of Correction ***Accept***

Plan of correction: Appropriate phone numbers were posted to the two telephones in question on 3/16/22 during the inspection by [redacted], Administrator in Training.
Both telephones were recently placed in these locations and the appropriate phone number directory was not replaced when new phones were set up.
The area surrounding and in close proximity to all accessible telephones will be checked for appropriate emergency numbers weekly and documented on log sheet by Hannah Sauers or designated member of the facility.

See Attached:
1. Picture of Foyer Phone
2. Picture of Reception Desk Phone
3. Emergency Phone Number Posting Log Sheet
4. Staff Education

Completion Date: *03/16/2022*

Document Submission ***Implemented***

see attached

95 - Furniture and Equipment

1. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 3/15/22, the faucet in the shared bathroom for bedroom #S1 was leaking water around the handle for the sink. The water was leaking down the faucet and along the edge of the sink top. Interview indicates the water leaks onto the floor.

Plan of Correction ***Accept***

Plan of Correction: Faucet was repaired on 3/24/22 by repair man after it was determined that a new washer was needed and replacement of entire faucet was unnecessary.
Room checks are completed weekly, sink/faucet checks will be added to current room checklist and completed by [redacted], Administrator-in-Training, or designated member of management.
Staff Education provided by Administrator [redacted], to educate staff on the importance of paying attention to the conditions of furniture and equipment and reporting concerns, malfunction and repairs to a member of management immediately.

See Attached:

95 - Furniture and Equipment (continued)

1. Receipt of hardware purchase
2. Room checklist
3. Staff Education

Completion Date: *03/24/2022*

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 3/15/22, a large plastic food cart was partially blocking the exit from the home's kitchen, allowing an opening of only approximately 20 inches of egress .

Plan of Correction ***Accept***

Plan of correction: the food cart with wheels was moved from the doorway on 3/15/22 by [redacted], *Administrator-In-Training, correcting the violation immediately.*
The food cart is not secured in place that would block the door and it used frequently throughout the day for meal service to the dining room. It was not a permanent obstruction and can be easily moved by any individual in the facility.
Staff have been instructed to store the food cart in the pantry when not in use. Sign posted on door to not block.
Checklist to assess for doors to be free of obstruction that will be completed weekly by [redacted], *Administrator-In-Training or designated member of facility.*
Education provided to staff by Administrator [redacted] *on importance of keeping doors and exits free of obstructions.*

See Attached:
1. Picture of sign on door
2. Picture of food cart
3. Checklist for unobstructed routes
4. Staff Education

Completion Date: *04/08/2022*

Document Submission ***Implemented***

see attached

123b - Emergency Procedures Posted

1. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

On 3/15/22, the home's and the local municipality's emergency procedures were not posted in a conspicuous and public

123b - Emergency Procedures Posted (continued)

place in the home.

Plan of Correction ***Accept***

Plan of Correction: Please let it be known, that in addition to the home's most recent inspection summary, the facility and local municipality emergency plan was also located in the administrator's office, as it was being reviewed and updated from previous home to new owner operating name because discrepancies were found and needed to be corrected to be in compliance, as they had previously been posted correctly but had been discovered to be missing. Immediately, on 3/15/2022, the current operating plans were replaced and posted on the wall by the dining room in the upper level.
A log sheet will be completed by [redacted], Administrator-in- Training weekly to assess for the presence of the home and municipality's emergency operating plans.

See Attached:
1. Picture of Emergency Operations Plan in public location
2. Checklist for presence of plans located in public locations

Completion Date: *03/15/2022*

Document Submission ***Implemented***

see attached

131f - Fire Extinguisher Inspection

1. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

On 3/15/22, the fire extinguisher in the outside smoke area has not been inspected by a fire safety expert.

Plan of Correction ***Accept***

Plan of Correction: The inspection tag was discovered missing, due to it being exposed to outside weather daily.
On 03/29/2022, our pre-scheduled annual fire extinguisher inspection was completed by [redacted] Fire, Inc. and a new tag was attached to all fire extinguishers both inside and outside of the building.
A weekly checklist will be completed to assess for the presence of the most current fire extinguisher inspection tag on all fire extinguishers inside and outside of the building. This will be completed by [redacted], Administrator-In-Training or a designated facility member.
Staff education was provided by Administrator [redacted]

See Attached:
1. Picture of current 2022 fire extinguisher tags
2. Checklist for Fire Extinguisher Tags
3. Staff Education

Completion Date: *03/29/2022*

Document Submission ***Implemented***

see attached

132a - Monthly Fire Drill

1. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of December 2021.

Plan of Correction ***Accept***

Plan of Correction: An unannounced fire drill WAS held during the month of December, 2021, however it was not recorded in the fire drill log book.
Documentation was located by [redacted] on 03/16/2022, from the facility's alarm monitoring company, 2 Krew Security & Surveillance, that upon the reinstatement of the DHS regulation of performing monthly fire drills, that a fire drill and annual inspection were held on 12/23/2021 at 13:40 (1:40 pm) while the company was at the facility to perform an annual test of the system with the company on site.
Documentation of drill results also noted on paperwork .
A weekly checklist to assess for documentation of monthly fire drills will be completed by [redacted], Administrator-in-Training or a designated facility member.

See Attached:
1. Documentation of annual inspection and fire drill conducted 12/23/2021
2. Checklist for fire drill log book

Completion Date: *03/16/2022*

Document Submission ***Implemented***

Pending March Fire Drill

133.2 - Exit Signs Direction

1. Requirements

2600.
133.2. Exit Signs - The following requirements apply for a home serving nine or more residents: If the exit or way to reach the exit is not immediately visible, access to exits shall be marked with readily visible signs indicating the direction to travel.

Description of Violation

On 3/15/22, there was no direct visual line from the dining room to the exit from the kitchen. There are no signs marking the line of travel to the exit. On 3/15/22, the home served 23 residents.

Plan of Correction ***Accept***

****REQUEST FOR WITHDRAWAL OF VIOLATION****
Plan of correction: On 3/15/22 surveyor was shown the exit sign, by Administrator-in-Training [redacted], that had been in the dining room, that was in the office that was removed for painting project.
Sign to be reposted once the painting of the dining room is complete. A paper exit sign was placed on 03/16/2022, which is currently posted by the kitchen door while renovations occur.
***REQUEST FOR WITHDRAWAL** Surveyor [redacted] was aware that there was an "EXIT" sign posted in the kitchen, above the exterior door. [redacted] stated that you could not visualize this sign. I have attached a picture of this sign, from sitting height, from the dining room tables located furthest from the kitchen door that shows the black and red exit sign above the exterior door. This sign is in clear view of residents that would be sitting in the dining room.*

133.2 - Exit Signs Direction (continued)

See Attached:
1. Temporary paper EXIT sign placed in dining room on the day of inspection
2. Pre-Existing EXIT sign above the exterior door in the kitchen prep area

Completion Date: *03/16/2022*

Document Submission ***Implemented***

Violation Withdrawn JW 4/19/22

183d - Prescription Current

1. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 2/15/22, multiple medications for resident #2, including discontinued medication, [redacted], discontinued on 2/21/22 and discontinued medication, [redacted], were sitting on top of a box under the desk in the reception office.

Plan of Correction ***Accept***

Plan of Correction: Immediately, on 3/15/22, [redacted], Administrator-In-Training, removed said medications from office. Medications will be disposed of appropriately. Discontinued medications will be kept in locked office and/or med room until they are disposed of in a timely manner.
Please be aware that discontinued medications placed in the office do not include controlled substances, which are kept double-locked in the medication room. Also please be aware that discontinued medications are kept out of sight, under the desk in the Administrator's office, which is occupied by a member of management at all times if unlocked and is otherwise locked, thereby medications being locked and stored safely.
On 03/16/2022, medications were destroyed using pharmacy-purchased Drug Buster formula and documented on medication destruction log sheet.

See Attached:
1. Medication Destruction Log Sheet
2. Bottle of Pill Buster

Completion Date: *03/16/2022*

Document Submission ***Implemented***

NA

190b - Insulin Injections

1. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

On 3/16/22, at 7:30 am., staff person B, who has not completed the Department-approved diabetes patient education

190b - Insulin Injections (continued)

program within the past 12 months, checked the blood glucose of resident #4 on 3/16/22 at 7:30 a.m.

Plan of Correction ***Accept***

Plan of Correction-
REQUEST FOR REMOVAL OF VIOLATION
This regulation states that a staff person must complete a department approved diabetes patient education program within the past 12 months to "administer insulin injections".
Currently, and current to the inspection as well as prior to the inspection, there have been no insulin-dependent diabetics housed in the facility. At no time have staff been required to administer insulin to any residents.
Staff certified in medication administration have checked blood sugars through the use of a blood glucose monitor that has been taught and signed off on by a licensed medical professional (RN) as a vital sign, given that there is no medication being administered such as insulin.
Please be aware that in 5 years of operating personal care home facilities, I have used several different agencies that have provided department approved diabetic certification to staff persons and at no time have they ever taught or include the training or use of a blood glucose monitoring system, otherwise known as a glucometer.
During the inspection, I contacted the [redacted] Memorial Hospital Diabetic Educator, [redacted], to assess whether or not they have re-incorporated that in to their diabetic certification classes offered to direct care personnel. She stated that "no", they did not teach use of glucometers because there are such a wide variety, training on a the use of a specific glucometer would not be encompassing enough.
In addition to this information, please be aware that the following medical professionals are trained on-the-job in using glucometers, but do NOT administer medications:
a. EMTs in emergency services are trained and signed-off on use of glucometers. Not licensed to administer medications
b. Unlicensed aides in acute care facilities, such as hospitals, are trained and signed-off during new hire orientation on how to use a glucometer on patients. Not licensed to administer medications.
c. CNAs/TNAs in Skilled and Longterm Care Nursing Facilities are trained and signed-off on how to correctly use a glucometer to check blood sugars of patients. Not licensed to administer medications.
In other areas of training, individuals of all ages, including small children as young as 5 years old, are taught how to use a glucometer to check blood sugars. In emergency services, a blood glucometer, even for a non-diabetic, is now considered a "vital sign" and is frequently assessed despite lack of history of diabetes or concerns of.
I feel it is putting personal care home level staff and owners at a disadvantage in that you are requiring PCH facilities, typically on the lowest end of the healthcare spectrum in regards to acuity, to spend time and money on training individuals to have a medication administration certification, who may not be appropriate to be certified to administer medications in order for them to use a glucometer to check a blood glucose level. In the event of an emergency, this could potentially be putting a resident at increased risk of an acute event if you restrict this "vital sign" to only those that are medication administration certified and also must have a diabetic certification for insulin administration, when they are not administering insulin.
Regardless, a class for diabetic education was already scheduled and completed on 04/04/2022 by the Diabetic Educator from [redacted] County Memorial Hospital, [redacted], RN.
All certified medication administration technicians received their Diabetic Education and Insulin Administration Certificate.
Administrator [redacted] has also attached a copy of Staff Person B certificate in addition to requesting that this violation be retracted.

Completion Date: *04/04/2022*

190b - Insulin Injections *(continued)*

Document Submission ***Implemented***

see attached

225a - Assessment 15 Days

1. 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

Resident #4 was admitted on 2/14/22; however, the resident's assessment was not completed.

Plan of Correction ***Accept***

Plan of Correction: The RASP for Resident #4 was completed by Administrator [redacted] on [redacted], reviewed and signed by Resident #4 on [redacted].
Future plan to prevent violation of this regulation will be a monthly calendar, created and managed by [redacted], Administrator-In-Training, in which all RASP due dates will be written down and highlighted upon completion.
Furthermore, an Audit tool will be completed monthly by [redacted] or other designated facility member to audit each resident's chart for appropriate documentation and completion of required information.

See Attached:
1. Completed RASP for Resident #4
2. Monthly Calendar for RASP due dates
3. Audit Tool for Resident Chart

Completion Date: *03/19/2022*

Document Submission ***Implemented***

see attached

227a - Support Plan 30 Days

1. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #4 was admitted on [redacted]; however, the resident's initial support plan was not completed.

Plan of Correction ***Accept***

Plan of Correction: The RASP for Resident #4 was completed by Administrator [redacted] on [redacted], reviewed and signed by Resident #4 on [redacted].
Future plan to prevent violation of this regulation will be a monthly calendar, created and managed by [redacted], Administrator-In-Training, in which all RASP due dates will be written down and highlighted upon completion.
Furthermore, an Audit tool will be completed monthly by [redacted] or other designated facility member to

227a - Support Plan 30 Days (continued)

audit each resident's chart for appropriate documentation and completion of required information.

See Attached:
1. Completed RASP for Resident #4
2. Monthly Calendar for RASP due dates
3. Audit Tool for Resident Chart
Completion Date: *03/19/2022*

Document Submission ***Implemented***

see attached