



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **HEARTFUL HANDS LLC**
LEGAL ENTITY

To operate **HEARTFUL HANDS LLC**
NAME OF FACILITY OR AGENCY

Located at **514 MITCHELL AVENUE, CLARITON, PA 15025**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **36**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller. (MAXIMUM CAPACITY)

Restrictions: _____

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **November 29, 2023** until **November 29, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **453700**

Janette Biderup
ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing Date: November 29, 2023

[REDACTED], Owner
Heartful Hands LLC

RE: Heartful Hands LLC
514 Mitchell Avenue
Clairton, Pennsylvania 15025
License #: 45370

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) licensing inspections on July 28, 2023, August 18, 2023, and October 20, 2023, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

A handwritten signature in black ink that reads "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

Facility Information

Name: *HEARTFUL HANDS LLC* License #: *45370* License Expiration: *11/02/2023*
Address: *514 MITCHELL AVENUE, CLAIRTON, CLARITON, PA 15025*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *HEARTFUL HANDS LLC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *06/14/2010* Issued By: *City of Clairton*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *32* Waking Staff: *24*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Complaint, Provisional, Incident* Exit Conference Date: *08/30/2023*

Inspection Dates and Department Representative

07/28/2023 - On-Site: [REDACTED]
08/18/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *36* Residents Served: *31*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *29* Are 60 Years of Age or Older: *21*
Diagnosed with Mental Illness: *17* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *1* Have Physical Disability: *0*

Inspections / Reviews

07/28/2023 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/15/2023*

09/18/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/10/2023

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 09/25/2023

09/27/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/10/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 10/04/2023

11/13/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/10/2023

Reviewer: [REDACTED]

Follow-Up Type: Exception

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 Standard Act , enacted 9/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. If the carbon monoxide alarm operates by a battery, the battery may not be removed for any length of time beyond that necessary to change the battery. The battery must be labeled with the date of installation and replaced at least once annually. On 7/28/2023 at 11:25 am, the carbon monoxide alarm for gas furnace #2 was located within 5 feet of the furnace and the carbon monoxide alarm for gas furnace #4 was located within 8 feet of that furnace. Also, both of the carbon monoxide alarms did not include the date of battery installation, so it could not be determined if the batteries were replaced annually.

Plan of Correction

Accept (redacted) - 09/18/2023)

Immediate Action:

8/2/23.The administrator had the carbon monoxide monitor located near furnace #2 moved to an area approx 17 feet from the furnace.

8/2/23 The administrator had the carbon monoxide monitor located too close to furnace #4 moved to an area approx 17 feet from the furnace.

8/2/23 The administrator had all carbon monoxide detectors batteries changed.

8/2/23 The monitors were labeled with the date battery was changed.. Photo will be attached to the POC

Continued Compliance:

Quarterly, the Administrator or designee will have all carbon monoxide detectors checked for proper operation. The quarterly check will be documented on the building check list by the administrator or designee. The quarterly checks will be reflected the quarterly Quality management report.

Quarterly checks will begin 3rd quarter of 2023 (October 2023) (Attached)

Licensee's Proposed Overall Completion Date: 10/16/2023

Implemented (redacted) - 11/13/2023)

63a - First Aid/CPR Training

2. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 7/21/2023 and 7/24/2023, from 7:00 pm to 11:00 pm, 33 residents were present in the home. Staff persons A and B were present during that time, however, neither were certified in first aid or certified in obstructed airway techniques and CPR.

63a - First Aid/CPR Training (continued)

Plan of Correction

Accept [redacted] - 09/18/2023)

Immediate:

Staff persons A was CPR/first aid trained on 4/2/23. The Card/Certificate is being retrieved from the provider. The certificate/card will be provided to the department upon receipt from the provider.

CPR first aid class has been scheduled for 9/22/23. Staff person is no longer employee. Those hired after the 7/28/23 inspection will attend the CPR class scheduled for 9/22/23. Documentation will be kept in the file and will be attached to the POC

Continued Compliance:

The administrator or designee will monitor the schedule to ensure one CPR/First Aid Certified staff member is in the bld at all times

A Heart notation will be placed by the staff persons name on the schedule, signifying they are certified. Notation on the schedule will begin 9/22/23.

documentation of training and schedule to be attached to the POC

CPR/First Aid will be addressed in the Quarterly Quality Management Report

Licensee's Proposed Overall Completion Date: 09/22/2023

Implemented [redacted] - 11/13/2023)

65a - FS Orientation 1st Day

3. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

The documentation for orientation training in accordance with 2600.65a for staff person C, hired [redacted]/23, was not dated. Therefore, it was not possible to determine if the training was completed timely.

Repeat Violation 12/15/2022

Plan of Correction

Accept [redacted] - 09/18/2023)

Immediate: Staff person C is no longer employed.

Continued Compliance:

The administrator will audit all current employee files for possible errors. The audit will take place by 10/16/23.

Audit to be submitted.

65a - FS Orientation 1st Day (continued)

The administrator or designee will not place a new hire on the schedule until the requirements of 2600.65a are met. The new hire check list will be used (attache) New hire files and check list will be reviewed by a second person prior to scheduling. Second signature will be implemented immediately for any new hires and by 10/16/23 for any file found deficient on the Audit to be completed by 10/16/23. Any new hire will have two signatures, the Adm and designee review and si thgne new hire check list . To be attached to the POC

Licensee's Proposed Overall Completion Date: 10/16/2023

Implemented () 11/13/2023)

65b - Rights/Abuse 40 Hours

4. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

- 1. Resident rights.
- 2. Emergency medical plan.
- 3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § 10225.101—10225.5102).
- 4. Reporting of reportable incidents and conditions.

Description of Violation

The documentation for orientation training in accordance with 2600.65b for staff person C, hired () /23, was not dated. Therefore, it was not possible to determine if the training was completed timely.

Repeat Violation 12/15/0222

Plan of Correction

Accept () - 09/18/2023)

Immediate: Staff person C is no longer employeed.

Continued Compliance:

Training required by 2600.65b will be completed by the administrator or designee prior to the new hire being placed on the schedule. The orientation will be signed by two managers. The new hire check list will be used to confirm training is complete and is signed. Both the Check list and the orientation will be signed by two people. Audit of all current staff will be completed by 10/16/23 and will be attached to the POC.

Training for the ADM and possible designee will be completed 9/14/23

Training will be attached to the POC

Licensee's Proposed Overall Completion Date: 10/16/2023

Implemented () - 11/13/2023)

65g - Annual Training Content

5. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

Description of Violation

Staff person D did not receive training in residents' rights during training year 2022.

65g - Annual Training Content (continued)

Plan of Correction

Accept (████ - 09/18/2023)

Immediate: Staff person D did have the required Resident rights training in 2022.

It was faxed to the department when located the day after the inspection. It was faxed to the attention of █████ and will be attached to this OC

Continued Compliance:

Staff and volunteer required training will be monitored by the administrator or designee. The quarterly Quality Management plan addresses the progress of the early training for Administrator and for staff.

Attached staff training plan and Quality Management Report

The Quality Management report for the 3rd quarter will be complete by 10/16/23 and attached to this POC

Licensee's Proposed Overall Completion Date: 10/16/2023

Implemented (████ - 11/13/2023)

85a - Sanitary Conditions

6. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

The following unsanitary conditions were observed on 7/28/2023:

- * *At 10:40 am, resident #1's sheets were covered with rolling tobacco.*
- * *At 10:47 am, the ventilation fan on the ceiling of bathroom #6 was coated with dust.*
- * *At 10:56 am, there was a soiled disposable incontinence pad on the floor in front of the commode in bathroom #7. The front of the incontinence pad was soaked with urine. There was also urine on the floor in front of the commode.*
- * *At 11:00 am, the white painted banister at the home's main staircase was coated with grime.*

Plan of Correction

Accept (████ - 09/27/2023)

Immediate: Bed of resident #1 was changed. Fan in bathroom #6 was taken down and cleaned on 8/3/23_.

Incontinence pad on the floor in bathroom #7 was removed. The floor in bathroom #7 was mopped. Banister was thoroughly cleaned (photo attached to POC)

Continued Compliance:

9/17/23

Direct Care staff re educated on the disposal of incontinence supplies and general housekeeping tasks such as the banister. Training will take place on 9/14/23. Attached to POC

**A two hour bathroom check to be completed by staff initiated 9/1/2023 to spot check for accidents and supplies. Attached. The Administrator or designee will check the bathrooms and the check sheet at random times 5 times per week*

and document on the 2 hour check list Any problems will be addressed with the appropriate staff. Check list with Adm initials will be attached to the POC.

** Resident # 1 was counseled on 9.11.23 that █████ cannot role cigarettes near █████ bed. █████ is a non-smoker and denies rolling cigarettes. Attached to POC*

The Administrator or designee will acheck the bed linens monthly.

85a - Sanitary Conditions (continued)

The first monthly check will take place the first week of Oct 2023. Attached

Licensee's Proposed Overall Completion Date: 10/16/2023

Implemented (redacted) - 11/13/2023)

87 - Lighting

7. Requirements

2600.

87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

On 7/8/2023, at approximately 10:55 am, the overhead light in bedroom #12 was inoperable.

Plan of Correction

Accept (redacted) - 09/18/2023)

Immediate: Switch was replaced on 8/14/23. The light now comes on immediately.

Continued compliance:

Overhead lighting added to the monthly check list. (attached) The Administrator or the designee will walk the building monthly to identify items needing repair or replacement. Staff will be re-educated on 9/14/23 on the use of the Maintenance Request. Training attached to POC
Maintenance requests will be reviewed by the administrator daily beginning 9/15/23
The Monthly Walk through will begin week of 10/2/23. Maintenance requests will be kept in the homes office. The monthly walk through check list to be attached to the POC

Licensee's Proposed Overall Completion Date: 10/16/2023

Implemented (redacted) - 11/13/2023)

95 - Furniture and Equipment

8. Requirements

2600.

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

Description of Violation

On 7/28/2023, at 11:10 am, the back portion of resident #2's bedside table was pulled away from the frame, exposing multiple sharp commercial grade staples.

Plan of Correction

Accept (redacted) - 09/27/2023)

Immediate: Night stand removed, repaired and returned on 7/31/23.
The night stand was removed and repaired and returned the same day.
Continued compliance.

9/14/23 Staff re educated on the importance of and use of the maintenance request. Attached.
The Administrator or designee will walk the bld monthly to identify items that are in need of repair or replacement.
The walk through will begin week of 10/2/23.
Maintenance requests will reviewed daily by the administrator or designee. MA requests will will kept in the bld for

95 - Furniture and Equipment (continued)

review. Check list maintenance request will be attached to the POC

Maintenance requests will be kept in the office for review.

The administrator or designee will do a walkthrough of the bld, bedrooms, bathrooms and common areas to identify item in need of repair or replacement.

The first walk trough will take place the first week of Oct 2023. Attached

* The adminisrator will walk-through all bedroom monthly. Documentation will be kept in the office

Licensee's Proposed Overall Completion Date: 10/16/2023

Implemented (█ - 11/13/2023)

100a - Exterior - Free of Hazards

9. Requirements

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 7/28/2023, at approximately 9:02 am, the concrete landing before the steps to Mitchell Avenue in front of the home was deteriorated in 2 areas. One area measured approximately 60 inches across by 3 inches to the widest point, and the second area was deteriorated in the shape of an arch that measured approximately 60 inches at the longest point by approximately 5 inches at the widest point, and was approximately 1/2 inch deep. Both areas are located on an egress route and present a trip and fall hazard for residents.

Plan of Correction

Accept (█ - 09/18/2023)

Immediate: A contractor was located to repair the deteriorated areas. The repair took place Aug 7, 2023. Photo attached.

Continued An outdoor check list has been created. (attached)

The Administrator or designee will walk the outdoor area monthly to identify any need for maintenance or repair.

The maintenance request will be submitted to the newly hired bld project manager who will locate the proper repair person, gain approval from the owner, order supplies as necessary and see that the repair is complete.

The monthly outdoor area monitoring will begin week of 10/2/23. Maintenance request will be kept in the office.

Major repairs will be reflected in the Quality Management quarterly reports. Out door check list and Quality management report will be attached to the POC

Documentation will be kept in the office.

Licensee's Proposed Overall Completion Date: 10/16/2023

Implemented (█ - 11/13/2023)

101j1 - Mattress Fire Retardant

10. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

101j1 - Mattress Fire Retardant (continued)

1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

On 7/28/2023, at 11:08, resident #3's mattress was broken down on the front edge and torn in 6 different places. The springs were visible through the holes.

Plan of Correction

Accept ([REDACTED] 09/27/2023)

Immediate: The mattress for resident # 3 was replaced on 8/1/23. Dated the mattress was put into service was written with permanent marker on the side of the mattress.
Photo attached

Continued compliance:

An audit of each bed was completed 9/8/23 The audit was completed by the newly hired Facility project manager. The audit revealed 4 mattresses that need replacement. Rm #4, Room #5,, Rm # 9 Rm # 10.

Mattresses were ordered on Sept 7, 2023. Order Attached to POC

* Beginning 8/1/23 any new mattress put into place will be logged and the mattress label with the date put into service.

* Quarterly the Administrator or facility project manager will inspect all mattresses to identify the need for replacement. Form attached. to POC

First inspection was completed 9/8/23. Next inspection will take place Dec 2023 or sooner if there is resident request or a need observed by staff.

Purchases of new mattresses or major appliances will be reflected in the quarterly QA report. Audit/ Receipts of Purchases and the QA report will be attached to the POC

Licensee's Proposed Overall Completion Date: 10/16/2023

Implemented [REDACTED] - 11/13/2023)

101j2 - Bedroom Chairs**11. Requirements**

2600.

101.j. Each resident shall have the following in the bedroom:

2. A chair for each resident that meets the resident's needs.

Description of Violation

Bedroom #12 is occupied by 3 residents; however, there were only 2 chairs in this room.

Plan of Correction

Accept [REDACTED] - 09/18/2023)

Immediate: Another chair was placed in room 12. There are three residents in the room and three chairs available.

Continued compliance:

9/9/23 and audit of rooms was completed by Newly hired Project Manager,

Four beds were found to have missing chairs. They were located at random places in the bld and returned to the appropriate room. Chairs have been labeled with room numbers for ease of return should they float to another area.

Re-education of the staff on the requirements of 2600.101 to be completed 9/14/23. Staff is required to check the requirements at the time of each weekly room clean. If there is a problem it should be reported via the

101j2 - Bedroom Chairs (continued)

maintenance request. Attached

Monthly; The Administrator or designee will round the building. Using a check list they will access the bedrooms for the the requirements of 2600.101.

The next audit will take place in Week of Oct 2, 2023 and monthly thereafter. The check list will be attached the POC and kept in the office files.

Licensee's Proposed Overall Completion Date: 10/16/2023

Implemented (████) - 11/13/2023)

101j3 - Bed/Linens/Pillows/Blankets

12. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

- 3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 7/28/2023, at 10:40 am, there was no pillow case on resident #1's bed.

On 7/28/2023 at 11:05 am, there was no pillow case on resident #4's bed.

Plan of Correction

Accept (████) - 09/18/2023)

Immediate: Resident # 1 was provided with a new pillow. Resident #4 was provided a pillow case.

Continued compliance:

9/14 23 Re-education of staff on 2600.101j. Education completed by ██████████ Attached. Staff is to check linen as they make beds in the AM

Administrator or designee will randomly inspect rooms for pillow cases and other linen one time per week. Check list attached to PO

Weekly rounds to inspect linen will begin the week of OCT 2, 2023 Attached

Licensee's Proposed Overall Completion Date: 10/02/2023

Implemented (████) - 11/13/2023)

101j7 - Lighting/Operable Lamp

13. 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.

101j7 - Lighting/Operable Lamp (continued)

Description of Violation

On 7/28/2023, at approximately 10:52 am, there was no source of lighting that could be turned on/off from bedside for resident #1. The bedside lamp was inoperable. Also there was no source of lighting that could be turned on/off from bedside for residents #5 and #6. Their shared bedside lamp was inoperable.

Plan of Correction

Accept [redacted] - 09/18/2023)

Immediate:

Lamp was replaced for resident #1

Lamp was replaced for residents #5 and # 6

Photos's Attached to POC

Continued Compliance:

9/9 /23 Audit of each room was performed by the facility project manager, accessing for bedside lamps and the requirements of 2600.101. A report was submitted to the Administrator. Attached

9/14/23 Staff re-educated on the requirements of 2600.101j . Education done by Resident Care manager and Facility Project Manager. (attached)

Weekly: When weekly room cleaning take place the statues of bedside lamps will be checked. If one is missing or broken, the maintenance form will be used.

Education on the Maintenance check list completed 9/14/23. Attached

Monthly: the Administrator or designee such as the Project Manager will round the bld to access the lighting and other requirements of 2600.101. Both the bedside lamps and the light switches will be checked. A check list will be used (attached) First round by the administrator or designee will take place in Oct 2023. Check list attached

Licensee's Proposed Overall Completion Date: 10/16/2023

Implemented (JW - 11/13/2023)

105g - Lint Removal and Duct Cleaning

14. Requirements

2600.

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 7/28/2023, at approximately 11:30 am, the lint trap in the Hot Point dryer on the left side of the basement was caked with 3 layers of lint, approximately 1/4 inch thick, from multiple loads of laundry.

Plan of Correction

Accept [redacted] - 09/27/2023)

Immediate: Lint was removed

Continued compliance:

105g - Lint Removal and Duct Cleaning (continued)

9/14/23 Staff re educated on the hazards of the lint trap being full.

9/14/23 New sign placed on the dryers as a reminder (attached)

Beginning 9/18 /23 the Administrator or designee will will check the dryers Daily at varying times. Adm/designee checks will be documented on clip board kept at the dryers. Attached to POC

Licensee's Proposed Overall Completion Date: 09/19/2023

Implemented ([redacted] - 11/13/2023)

107a - Emergency Preparedness

15. Requirements

2600.

107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

Description of Violation

The home does not have the emergency preparedness plan for the local municipality.

Plan of Correction

Accept [redacted] - 09/18/2023)

Immediate: The newly hired Administrator was shown the location of the local municipalities emergency plan. It was on the main bulletin board in the first floor hallway. [redacted] was not been able to locate it the day of inspection. It was there but overlooked Education completed and attached. Education completed 8/3/23 Attached to POC

Continued Compliance:

A Posting check list will be placed on the first floor bulletin board by Oct 1, 2023

Monthly: Using the check list, the administrator or designee will locate each required posting . Attached to POC

|

Licensee's Proposed Overall Completion Date: 10/01/2023

Implemented [redacted] - 11/13/2023)

132d - Evacuation

16. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

On 6/8/2023 at 3:10 pm, the home conducted a fire drill with 34 residents present in the home; however, only 33 residents evacuated the home.

Plan of Correction

Accept [redacted] - 09/27/2023)

Immediate: The fire drill record was reviewed. The census for 6/8/23 was reviewed.

Total building census was correct at 34. One resident was resistant and refused. [redacted] has [redacted] diagnosis and was

132d - Evacuation (continued)

extremely fearful.

Continued Compliance: Resident [redacted] was re- assessed for transfer to [redacted] wheelchair. [redacted] can physically transfer but [redacted] will require the assist of two if [redacted] is resistant.

On the fire drill of 7/29/23, [redacted] cooperated and was evacuated via wheelchair.

on the fire drill of 8/30/23, [redacted] cooperated and was evacuated by wheelchair.

[redacted] the resident, can walk with a walker but is slow and inconsistent, using the wheelchair is more timely and safer. The wheelchair had previously been ordered for this purpose.

[redacted] will to be re- accessed if there is another episode that [redacted] refuses. A significant change will be noted in the Assessment and Support plan. Possible 30 day notice will be given if [redacted] is unable or unwilling to evacuate with the assist of two and the use of the wheelchair.

Documentation will be in the fire drill record and will be attached to the POC

Monitoring Step: The Administrator will monitor the fire drill record for any drill she did not personally observe, to ensure all evacuate for the fire drills.

The administrator will initial each drill record to document she has reviewed the drill information

This monitoring will begin with the drill in the month Of Sept 2023

Licensee's Proposed Overall Completion Date: 10/16/2023

Implemented [redacted] - 11/13/2023)

132e - Fire Drill Sleeping Hours

17. Requirements

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on an unspecified date in May 2023 at 5:30 am. The previous sleeping hours fire drill was conducted on 8/7/2022 at 12:00 am.

Plan of Correction

Accept [redacted] - 09/18/2023)

Immediate: The fire drill record was reviewed and the Administrator and manager4 were re- educated on 9/14/23. Attached

Continued Compliance

Adm reviewed the requirement of 132e. Documentation attached.

The next unannounced fire drill will take place in September. It will be during sleeping hours. The next night time drill will be within 6 months.

The fire drill log will be reviewed by both the Administrator and the Resident Care Director for the accuracy of the documentation and for the timing of night drills. Each drill will be initialed by both.

The month the sleeping hours drill is to take place will be highlighted on the Drill record. Education and Drill record Attached to POC

Licensee's Proposed Overall Completion Date: 09/14/2023

Implemented [redacted] - 11/13/2023)

252 - Record Content

18. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

Description of Violation

Resident #7's record does not include a photograph that is no more than 2 years old.

Plan of Correction

Accept [REDACTED] - 09/18/2023)

Immediate: Audit was completed and residents all had new photographs taken and placed in the record. Photos were updated by the administrator 8/17/23.

Continued Compliance:

Photos will be checked by the resident care manager at the time of the annual assessment and support plan. The summary page on the RASP will document the photo has been reviewed and updated if necessary. New admissions will have the photo taken within 24 hours of the admission. Copy of Sept 2023 Rasps with summary pg to be attached to OC

Licensee's Proposed Overall Completion Date: 10/16/2023

Implemented [REDACTED] - 11/13/2023)

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

Facility Information

Name: *HEARTFUL HANDS LLC* License #: *45370* License Expiration: *11/02/2023*
Address: *514 MITCHELL AVENUE, CLAIRTON, CLARITON, PA 15025*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *HEARTFUL HANDS LLC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *06/14/2010* Issued By: *City of Clairton*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *34* Waking Staff: *26*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Provisional, Monitoring* Exit Conference Date: *10/20/2023*

Inspection Dates and Department Representative

10/20/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *36* Residents Served: *33*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *32* Are 60 Years of Age or Older: *22*
Diagnosed with Mental Illness: *18* Diagnosed with Intellectual Disability: *4*
Have Mobility Need: *1* Have Physical Disability: *0*

Inspections / Reviews

10/20/2023 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *Exception*

NO DEFICIENCIES FOUND