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

November 21, 2023

[redacted]
PINE VIEW PERSONAL CARE FACILITY, INC.
[redacted]

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

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/03/2023 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: *PINE VIEW PERSONAL CARE FACILITY* **License #**: *42669* **License Expiration**: *10/30/2023*

Address: *1113 PINE VIEW LANE, VANDERGRIFT, PA 15690*

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

Administrator

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

Legal Entity

Name: *PINE VIEW PERSONAL CARE FACILITY, INC.*

Address: [redacted]

Phone: [redacted] **Email**: [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**: *21* **Waking Staff**: *16*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *08/03/2023*

Inspection Dates and Department Representative

08/03/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *28* **Residents Served**: *20*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *6* **Are 60 Years of Age or Older**: *20*

Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

08/03/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/25/2023*

08/25/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/05/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/01/2023*

Inspections / Reviews *(continued)*

09/12/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/05/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/02/2023*

11/21/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/05/2023*

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

A copy of 55 Pa. code Chapter 2600 was not posted in a conspicuous and public place in the home.

A copy of the current license inspection summaries (LIS) issued by the Department, dated 12/1/22 and 9/15/22, was not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept [redacted] - 09/12/2023)***

Our inspection book was on the shelf in the office with the door open where it has been for several inspections and discussed with several inspectors. On the day of this inspection the book along with our emergency prepared plan was moved to a small table right inside the front door. It will continue to stay there.

On August 3, 2023 the administrator moved the inspection book and emergency preparedness plan to a table in the entry way of the home for all to see.

On August 3, 2023 the administrator moved the pink regulation book to the bulletin board in entry way for all to see and review.
The administrator did put up a note to review all information and to return it to the table/bulletin board when done.
The administrator does check the entry way daily to make sure the books are still in place for all to see

The administrator moved the book to the entry way along with the emergency prepared plan book, [redacted] did that immediately on August 3, 2023. In addition for the future it will be kept there and a sign was posted along with the books that after use to return the books to the table in the entry way for all to see daily.

Licensee's Proposed Overall Completion Date: *09/12/2023*

Implemented ([redacted] - 11/21/2023)

16c - Written Incident Report

2. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident #1 fell in the home on [redacted] and sustained a head injury that required emergency treatment at the

16c - Written Incident Report (continued)

hospital. The home failed to report this incident to the Department until 8/3/23.

Plan of Correction ***Accept [redacted] - 09/12/2023)***

Resident #1 is on hospice and did fall. The staff notified admin as it was on a Saturday. Residents family were called as well as hospice. Admin did fail to do an incident report. The admin did complete the incident form on August 3, 2023 during the inspection and emailed it to the department.
On August 4 2023 the two administrators met and went over the protocol steps of what is to be done when a incident does occur.
On August 4, a protocol of steps were drafted by the administrators and posted for all staff to read these steps will be followed to prevent future oversights.
This protocol of steps was posted in med room on August 4, 2023 by administrator

Licensee's Proposed Overall Completion Date: *09/12/2023*

Implemented ([redacted] - 11/21/2023)

51 - Criminal Background Check

3. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Direct care staff A, hired on [redacted] did not have a criminal history check completed.

Plan of Correction ***Accept ([redacted] - 09/12/2023)***

On August 3, 2023 during the inspection the administrator obtained the criminal record on staff person A.
On August 4, 2023 administrators revised the policy to l follow procedure on all new hires to obtain a criminal record upon date of hire for all employees moving forward not just on direct care staff person.

Licensee's Proposed Overall Completion Date: *09/12/2023*

Implemented ([redacted] - 11/21/2023)

65g - Annual Training Content

4. 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

Direct care staff B, hired on [redacted], does not have documentation of annual fire safety training by a fire safety expert during the 2022 annual training year.

Plan of Correction ***Accept ([redacted] - 09/12/2023)***

On August 23, 2023 the Ast. Fire Chief and fire safety expert met with staff person B and reviewed all required fire safety regulations with staff person B.
On August 23, 2023 the Ast. Fire Chief and fire safety expert also met with the administrator to go over all required fire safety training[redacted] discussed all steps at length and signed off that she could go over steps with all new hires.
On August 23, 2023 the fire chief agreed to go over all required steps with staff at the years fire drill/evacuation

65g - Annual Training Content (continued)

when his department is present with staff. The next drill with the department is expected June of 2024.

Licensee's Proposed Overall Completion Date: *09/11/2023*

Implemented (- 11/21/2023)

103f - Refrigerator/Freezer Temps

5. 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

The stand-up freezer in the kitchen did not have a working thermometer.

The refrigerator in the dining room measured 55 degrees at 10:32am, a new thermometer was placed in the refrigerator and measured 50 degrees at 11:53am.

Plan of Correction ***Accept (- 09/12/2023)***

On August 3, 2023 during the inspection the administrator placed new thermometer in the refrigerator also on this date the thermostat of the refrigerator was turned down to the appropriate temperature by the administrator.
On August 26, 2023 a new refrigerator was delivered. The maintenance planned on connecting it immediately however new counters, sink, and dishwasher have also been purchased by administrator. The plan now is to have the new refrigerator connected by this Friday September 15, 2023. This will be done by our maintenance . The maintenance will also place a new thermometer in the refrigerator to monitor its temperature the maintenance will check the thermometer daily when does walk through.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented - 11/21/2023)

103g - Storing Food

6. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

There was a 28-ounce bag of vanilla pudding mix and a 28-ounce bag of berry blue gelatin mix, both ¼ full, that was opened and unsealed in the kitchen cupboard.

Plan of Correction ***Accept - 09/12/2023)***

The administrator has purchased clips for all dry ingredients along with admin discussing this violation with the new cook on August 5, 2023. August 5, 2023 a memo has been posted in the kitchen to remind the cooks of proper storage it will also be discussed with new hires.
Admin continues to meet with the cooks and do walk throughs to make sure clips are being used and proper storage is being done. will do this on Tuesdays of every week.
In addition admin will continue to do on going training with staff reminders etc.

Licensee's Proposed Overall Completion Date: *09/12/2023*

103g - Storing Food *(continued)*

Implemented [redacted] - 11/21/2023)

132c - Fire Drill Records

7. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The home's fire drill record does not record the time of the following fire drills in hours and minutes:
**7/17/23 at 9 a.m.*
**6/19/23 at 7 p.m.*
**3/14/23 at 10 a.m.*
**2/7/23 at 7 p.m.*
**12/16/22 at 8 a.m.*
**10/25/22 at 4 p.m.*
**9/16/22 at 1 p.m.*

Plan of Correction ***Accept [redacted] - 09/12/2023)***

On August 4, 2023 the admin met and made a plan that for all future fire drills the exact time in hour and exact minutes will be documented. This was added to our fire drill policy August 22, 2023.

The administrator will do fire drills monthly, the admin. will document the exact time in hour and minutes along with date.
On August 22, 2023 the following were discussed with staff and posted
Admin will document any issues during drill
Admin will instruct staff to evacuate to the outdoor pavilion for all drills Admin will instruct ALL residents are completely evacuated.
In the event of a hospice patient being unable to evacuate staff will be instructed by admin to simulate the evacuation of that resident.
Next drill is scheduled 9/18/2023.

Licensee's Proposed Overall Completion Date: *09/11/2023*

Implemented [redacted] - 11/21/2023)

132h - Designated Meeting Place

8. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

132h - Designated Meeting Place *(continued)*

Description of Violation

There were 18 residents in the home during the fire drill conducted on 5/23/23 at 3:40 p.m. However, the home only evacuated 17 residents.

According to multiple resident and staff interviews, on multiple occasions over the past 12 months, the home has not evacuated residents outside of the home during fire drills which are conducted during inclement weather.

Plan of Correction ***Accept (- 09/12/2023)***

Please see the att. new fire drill policy - this policy was made by administrators on August 22, 2023. Explaining exact times in hour minutes will be documented evacuation procedures listing all residents will be evacuated including hospice unless actively dying If s simulations will be practiced for evacuations as well. All drills will be a complete exit to pavilion no matter the weather

As addressed above Admin will instruct all staff to evacuate all residents to the outside meeting place. In the event a resident is on hospice and evacuating practices would be to hard for the resident a simulation of the process to evacuate them will be done by staff.
The next fire drill is scheduled for September 18, 2023. On September 18, 2023 the admin will meet with staff prior to the drill, she will discuss the evacuation procedure, hospice simulation, and will document the exact time in minutes and seconds. Along with exact time of day. All residents will be evacuated to the pavilion.

Licensee's Proposed Overall Completion Date: *09/18/2023*

Implemented - 11/21/2023)

162c - Menus Posted

9. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The current week and advance weekly menus were not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept - 09/12/2023)***

On August 3, 2023 the menu for that day was posted. On August 4, the admin met with the cooks starting Monday August 7, 2023 a week of menus will be posted by the cook on bulletin board in the kitchen for all to see.
The admin checked on the new menu rotation of a month in advance and was told it will be completed by October 2, 2023. Once received the admin will post the monthly rotation in the kitchen and also by the activity calendar. A copy will be made and handed to each resident by the administrator on October 2, 2023.

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

Implemented - 11/21/2023)

185a - Implement Storage Procedures

10. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #1's glucometer indicates a blood glucose check reading of [redacted] on [redacted] at [redacted] a blood glucose check reading of [redacted] on [redacted] at [redacted] and blood glucose check reading of [redacted] on [redacted] at [redacted]. However, the home failed to document these readings.

Plan of Correction ***Accept [redacted] - 09/12/2023)***

On August 3, 2023 staff and admin reviewed documenting the low blood sugar. A policy was made by administrator on August 22, 2023 and discussed with the staff. This policy reviews the proper protocol for low blood sugar readings.

The protocol for low blood sugar documentation has also been posted August 22, 2023.
The admin and staff understand this documentation protocol and in the event of a low blood sugar reading will refer to it to assure proper documentation

Licensee's Proposed Overall Completion Date: *09/11/2023*

Implemented [redacted] - 11/21/2023)

190a - Completion Medication Course

11. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency tes[redacted]rs may administer oral; topical; eye, nose and ear drop prescription medications and [redacted] for insect bites or other allergies.

Description of Violation

Direct care staff #B, hired on [redacted] did not complete a Department approved medication administration annual practicum within the past 12 months. Direct care staff B administered the following medication to resident #[redacted] on 8/1/23, 8/2/23, 8/3/23:
At [redacted]
At [redacted]
At [redacted]

Plan of Correction ***Accept [redacted] - 09/12/2023)***

On August 3, 2023 the administrator went over the required observations and requirements for staff person B with the inspector.
On August 24, 2023 the administrator completed working with staff person B to redo all med training and observations.
On August 24, 2023 admin also review all other med passers' files to make sure they were in compliance.
On August 24, 2023 the admin marked her calendar and also made up a chart to refer to make sure all observations and reviews are done on each med passer as required.

Licensee's Proposed Overall Completion Date: *09/11/2023*

Implemented ([redacted] - 11/21/2023)

225a - Assessment 15 Days

12. 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 #2's initial medical evaluation indicates the following diagnoses: [redacted], severe [redacted]. However, the resident's initial assessment and support plan, dated 6/14/23, fails to address these diagnoses.

Resident #3's initial medical evaluation indicates the following diagnoses: major [redacted] with [redacted] and unspecified [redacted]. However, the resident's initial assessment and support plan, dated 3/24/23, fails to address these diagnoses.

Plan of Correction ***Accept ([redacted] - 09/12/2023)***

On August 4, 2023 the admin pulled the RASP, compared it to the medical evaluation and updated it to have all medical diagnoses present.
In addition the administrator completed reviewing all RASPS and med evals on August 28, 2023 to make sure all were correct.
The admin will continue to make sure all new admissions in the future have the RASP list all diagnoses.

Licensee's Proposed Overall Completion Date: *09/11/2023*

Implemented [redacted] - 11/21/2023)