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

February 21, 2024

[redacted], ADMINISTRATOR
PLEASANT RIDGE MATURE LIVING, LLC
[redacted]

RE: PLEASANT RIDGE MATURE LIVING
981 PLEASANT HILL ROAD
LEECHBURG, PA, 15656
LICENSE/COC#: 42940

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/06/2023 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: *PLEASANT RIDGE MATURE LIVING* **License #**: *42940* **License Expiration**: *09/09/2024*

Address: *981 PLEASANT HILL ROAD, LEECHBURG, PA 15656*

County: *WESTMORELAND* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *PLEASANT RIDGE MATURE LIVING, LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *10/29/1998* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *1* **Total Daily Staff**: *61* **Waking Staff**: *46*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *12/06/2023*

Inspection Dates and Department Representative

12/06/2023 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served**: *50*

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *19* **Are 60 Years of Age or Older**: *49*

Diagnosed with Mental Illness: *14* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *10* **Have Physical Disability**: *1*

Inspections / Reviews

12/06/2023 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *12/29/2023*

Inspections / Reviews *(continued)*

01/03/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/15/2024*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *01/10/2024*

01/10/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/15/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *02/15/2024*

02/21/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/15/2024*

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

The most recent license inspection summary, dated 5/10/22 et, al., was not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept [redacted] - 01/10/2024)***

LIS dated 5/10/2022 was placed in the binder in the common area of the lounge on 12/6/2023. State inspector was made aware of this and it was checked out by the state inspector. Monthly check will be done by the Resident Care Coordinator. First check was completed on 12/27/2023. Copy of check sheet attached.

Licensee's Proposed Overall Completion Date: *01/04/2024*

Implemented ([redacted] - 02/21/2024)

17 - Record Confidentiality

2. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

At 10:00 AM, the 1st floor medical records room was unlocked, unattended and accessible, which contained approximately 25 boxes of resident records and resident information, including resident-home contracts, resident social security numbers, resident insurance information, resident medical evaluations and resident assessments and support plans.

Plan of Correction ***Directed ([redacted] - 01/10/2024)***

Effective 12/27/2023 all medical records were moved to another room to be the new medical records room, door has coded panel to get in and the door shuts automaticly. Picture of new area is attached. All staff was educated by Resident care coordinator on 1/5/2024 where the medical records were moved to and the importance of ensureing that they are kept in a secure area. Sign in sheet attached. Assistant Resident Care Coordinator to check weekly for one month and monthly after This check will be kept in the Administrators office. (DIRECTED: The weekly checks shall begin on 1/15/24 and be conducted weekly for 1 month then monthly thereafter. The checks shall include an audit of the entire home to ensure all resident information is kept in an area that is locked. [redacted] 1/10/24).

Proposed Overall Completion Date: 01/05/2024

Directed Completion Date: *01/15/2024*

Implemented [redacted] - 02/21/2024)

65g - Annual Training Content

3. Requirements

2600.

65g Annual Training Content *(continued)*

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

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

Direct care staff person A, hired on [redacted] did not receive fire safety training completed by a fire safety expert or by a staff person trained by a fire safety expert during the 2022 training year.

Direct care staff person B, hired on [redacted], did not receive fire safety training completed by a fire safety expert or by a staff person trained by a fire safety expert during the 2022 training year.

Plan of Correction ***Directed ([redacted] - 01/10/2024)***

On 12/26/2023 Fire Safety Expert came in the facility and did a fire safety training for all staff. Copy of sign in sheet is attached. Staff persons A and B was also trained on 12/26/2023. (DIRECTED: Documentation of staff persons A and B's training shall be kept in accordance with 2600.65i. [redacted] 1/10/24). Administrator to check monthly training to ensure that all staff has the training complete each month. check sheet attached. (DIRECTED: The administrator monthly checks shall begin on 1/15/24 and shall also include a monthly review of the home's staff training plan and staff training sign in sheets to ensure all direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers receive training on all topics specified in 2600.65g during each training year. [redacted] 1/10/24)

DIRECTED; By 2/1/24: The administrator shall conduct a quality management review, which includes all topics specified in 2600.26b. Documentation of the quality management review shall be kept.

Proposed Overall Completion Date: 01/31/2024

Directed Completion Date: *02/01/2024*

Implemented ([redacted] - 02/21/2024)

88a - Surfaces

4. 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

At 10:35 AM, the homes ceiling mounted boiler tank was leaking a steady stream of water from the ceiling to the floor in the boiler room, creating an approximate 8 foot wet area on the floor.

The door latches have been removed from the door knobs of the exit doors at the main entrance and across from bedroom #202, preventing these doors from securely closing and latching into the door frames.

At 1:25 PM, a pipe in the ceiling of the home's medication room was actively leaking water. A bath towel, which was

88a - Surfaces (continued)

wet with water, was wedged between the ceiling track and ceiling tile. Staff persons indicated the water pipe routinely leaks.

At 10:58 AM, the push bar to operate the exit door in the home's dining room was not securely attached to the door. According to staff persons, the push bar falls off when you attempt to open the door.

Plan of Correction ***Directed (- 01/10/2024)***

1.On 12/27/2023 Valley Plumbing came and repaired the pipe. In wellness station, the hot water valves are automatic due to valve in boilerroom. Maintenance added condensation pan below auto bleeders. Bill not received yet. Picture attached of it being repaired
2. On 12/27/2023 Owner replaced door knob and placed a closer bar to the doorat the bottom entrance door. Door knob across room 202 exit door was replaced also by the Owner Pictures of this attached.
3. On 12/27 2023Owner replaced closer bar on the dining room door. Picture attached. Training was done on 1/3/2024 to housekeeping staff on checking items for the compliance of repairs needing done was completed. Sign in sheet and report sheets attached. Housekeeping to check these items weekly. The checks will be kept in the Administrators office. Maintence repair sheets placed in Wellness station to fill out and given to Maintence.
(DIRECTED: By 1/20/24: All staff persons shall be educated on the location of the maintenance repair sheets to ensure timely reporting to the home's management staff for items in need of repair or replacement. Documentation of the staff education shall be kept in accordance with 2600.65i. 1/10/24). First check was done on 12/27/2023. copy of repair sheets and check sheets attached (DIRECTED: The weekly checks conducted by housekeeping staff shall include a physical site inspection of the entire home to ensure all floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. Documentation of the weekly audits shall be kept for 1 month. 1/10/24

Proposed Overall Completion Date: 01/04/2024

Directed Completion Date: *02/01/2024*

Implemented (- 02/21/2024)

94b - Non-Skid Surface

5. Requirements

2600.
94.b. Interior stairs, exterior steps and ramps must have nonskid surfaces.

Description of Violation

There was no nonskid surface on the wooden landing and wooden ramp outside the emergency exit door between bedrooms #206 and #207.

Plan of Correction ***Directed (- 01/10/2024)***

On 12/27/2023 all outside area was of ramps and steps treated for alge and mold. This makes the wood non slick.When weather is acceptable,area will be painted with sand in the paint to ensure non slip.~~The painting wil be complete by July 30,2024~~ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. 1/10/24) (DIRECTED: By 2/15/24: A nonskid surface shall be added to the wooden landing and wooden ramp outside the emergency exit door between bedrooms #206 and #207. 1/10/24).

94b - Non-Skid Surface (continued)

Indoor steps have carpet on them and are non slip

DIRECTED: Beginning on 1/15/24, then monthly thereafter: The administrator/designee shall inspect all Interior stairs, exterior steps and ramps to ensure a nonskid surface is present. [redacted] 1/10/24).

Proposed Overall Completion Date: 01/04/2024

Directed Completion Date: *02/15/2024*

Implemented [redacted] - 02/21/2024)

101j7 - Lighting/Operable Lamp

6. 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

At 11:18 AM, resident #1's bedside lamp was approximately 12 feet from resident #1's bed and could not be turned on/off from bedside.

Plan of Correction ***Directed ([redacted] - 01/10/2024)***

On 12/6/2023, Assistant Resident Care Coordinator moved the lamp within the reach of the resident. This was completed while the state inspector was in the room. Check sheet was made and training done for Housekeeping to check rooms weekly to ensure all are within compliance. Sign in sheet and form attached to #4 above (DIRECTED: The weekly checks conducted by housekeeping staff shall begin on 1/15/24 and shall include a check of at least 10 resident bedrooms per week to ensure an operable lamp or other source of lighting is within reach of each resident's bed. [redacted] 1/10/24).

DIRECTED: By 1/20/24: All staff persons shall be educated that an operable lamp or other source of lighting must be within reach of each resident's bed. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 1/10/24

Proposed Overall Completion Date: 01/04/2024

Directed Completion Date: *01/20/2024*

Implemented [redacted] - 02/21/2024)

103f - Refrigerator/Freezer Temps

7. 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

At 10:40 AM, the temperature of the kitchen storage room freezer was 50 degrees Fahrenheit. At 2:50 PM, the temperature was 2 degrees Fahrenheit.

103f - Refrigerator/Freezer Temps (continued)

At 10:43 AM, the temperature in the kitchen freezer next to the exit door was 12 degrees Fahrenheit. At 2:50 PM, the temperature was 3 degrees Fahrenheit.

At 10:50 AM and at 2:49 PM, no thermometer was present in the commercial 3 door freezer, located in the home's kitchen.

Plan of Correction ***Accept ([redacted] - 01/10/2024)***

12/27/2028 N3 Mechanical came and repaired defrost timer . Copy of invoice will be sent when received. New Tempeture guages placed inside of freezers and refrigerators
12/28/2023 Kitchen staff to check temperatures of all coolers and freezers and write temp down on temperature form twice daily Form is attached. Temperature sheets will be kept by the Kitchen Manager.

Proposed Overall Completion Date: 01/04/2024

Licensee's Proposed Overall Completion Date: *01/04/2024*

Implemented ([redacted] - 02/21/2024)

121a - Unobstructed Egress

8. 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

At 10:45 AM, there was a 35' x 31" piece of particle board leaning against the emergency exit door, located in the home's kitchen storage room.

Plan of Correction ***Directed [redacted] - 01/10/2024)***

On 12/6/2023 Partical board was removed in front of the state inspector by The Assistant Resident Care Cordinator. Board was given to Housekeeping and was taken to the dumpster immediately. Housekeeping was trained on what to look for and remove while doing weekly building checks. (DIRECTED: The weekly checks conducted by housekeeping shall begin on 1/12/24 and shall include an inspection of all stairways, hallways, doorways, passageways and egress routes from rooms and from the building to ensure they are unlocked and unobstructed. LM 1/10/24).
Sign in sheet and form was added to number 4 above.

DIRECTED: By 1/20/24: All staff persons shall receive education that all stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed. Documentation of the

121a - Unobstructed Egress (continued)

education shall be kept in accordance with 2600.65i. [redacted] 1/10/24

Proposed Overall Completion Date: 01/04/2024

Directed Completion Date: *01/20/2024*

Implemented ([redacted] - 02/21/2024)

132g - Fire Drills Days/Times

9. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely schedules 2 staff persons during the 11:00 PM through 7:00 AM shift; however, the home has not conducted a fire drill with only 2 staff persons in the past year.

Plan of Correction ***Directed [redacted] - 01/10/2024)***

Overnight fire drill was performed on 12/28/2023 with two overnight staff on duty. Fire drill was performed in alloted time allowed to exit. Copy of sign in sheet attached. Administrator to ensure that overnight fire drills are done twice in 12 month period. This will be placed in the fire log. Administrator to check fire log monthly to ensure that fire drills are being held on different days, time and two overnights done in one year. (DIRECTED: The monthly administrator checks of the home's fire drill records shall begin on 1/12/24. [redacted] 1/10/24). Check sheet is attached and will be kept in the fire log book in the administrators office

Proposed Overall Completion Date: 01/04/2024

Directed Completion Date: *01/12/2024*

Implemented [redacted] - 02/21/2024)

162e - Menu Changes

10. Requirements

2600.
162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

Description of Violation

Salisbury steak, mashed potatoes, green beans and cake were indicated on the menu for lunch; however, BLT sandwiches, 3 bean salad, chips and jello were served. No advance notice was posted in a public and conspicuous place indicating the menu change.

Plan of Correction ***Directed [redacted] - 01/10/2024)***

Kitchen Manager to ensure that any change in the menu will be placed with the copy of the weeks menu on the bullitin board entering the dinning room. Copy of menus and change of menu will be kept by Kitchen Manager for one year. Administrator to check monthly to ensure that the Kitchen Manager is doing this procedure. (DIRECTED:

162e Menu Changes (continued)

Beginning on 1/12/24: The administrator shall check the home's posted menus daily for 2 weeks then weekly thereafter to ensure changes to the menu are posted in a conspicuous and public place in the home, are accessible to each resident and are posted in advance of the meal. [redacted] 1/10/24). Copy of change of menu is attached. Kitchen Manager to ensure that Administrator gets a copy of all menus and change in menu monthly and Administrator will keep in administrators office for one year.

DIRECTED: By 1/20/24: All kitchen staff persons shall be educated that a change to a menu shall be posted in a conspicuous and public place in the home, are accessible to each resident and are posted in advance of the meal. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 1/10/24

Proposed Overall Completion Date: 01/04/2024

Directed Completion Date: *01/20/2024*

Implemented ([redacted] - 02/21/2024)

184a - Resident's Meds Labeled

11. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #2 is prescribed [redacted] tablet Take 1 tablet by mouth every 4 hours as needed. Two medication cards for this medication were present in the home; however, the pharmacy label on 1 of the medication cards indicates [redacted] tablet Take 1 tablet by mouth every 6 hours as needed.

Plan of Correction ***Directed [redacted] - 01/10/2024)***

Change of order sticker was placed on the medication card on 12/6/2023 by the Assistant Resident Care Cordinator. [redacted] is to perform weekly cart audits for one month. Copy of cart audit form is attached. When audits are completed, Assistant Resident Care Cordinator to turn into Administrator and will be kept in binder in the Administrators office. Cart Audits started on 12/29/2023 and will continue weekly for one month and monthly there after. (DIRECTED: Each cart audit shall include an audit of at least 5 resident's medications to ensure accurate pharmacy labels are present on each medication in accordance with current prescribers' orders. [redacted] 1/10/24). All Med Techs will be trained on 1/5/2024 on the change of order sticker and to place on medication when order is changed. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 1/10/24). Sign in sheet is attached

Proposed Overall Completion Date: 01/05/2024

Directed Completion Date: *01/10/2024*

184a Resident's Meds Labeled *(continued)*

Implemented ([redacted] 02/21/2024)