





**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**Emailing Date: August 1, 2024**

[REDACTED]

RE: Northland Heights  
4859 McKnight Road  
Pittsburgh, Pennsylvania 15237  
License #:450840

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on February 21, 2024, February 23, 2024, March 27, 2024, April 8, 2024, April 10, 2024, and May 13, 2024, and the corrections you have made after our inspections, we have found the above facility to be in compliance with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence). 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: *NORTHLAND HEIGHTS* License #: *45084* License Expiration: *05/03/2024*  
Address: *4859 MCKNIGHT ROAD, PITTSBURGH, PA 15237*  
County: *ALLEGHENY* Region: *WESTERN*

**Administrator**

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

**Legal Entity**

Name: *NORTHLAND HEIGHTS LLC*  
Address: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-1* Date: *01/21/2020* Issued By: *Ross Township*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *58* Waking Staff: *44*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
Reason: *Renewal, Provisional* Exit Conference Date: *02/23/2024*

**Inspection Dates and Department Representative**

02/21/2024 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *123* Residents Served: *36*

**Special Care Unit**

In Home: *Yes* Area: *2nd Floor* Capacity: *19* Residents Served: *7*

**Hospice**

Current Residents: *3*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *36*  
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *1*  
Have Mobility Need: *22* Have Physical Disability: *3*

**Inspections / Reviews**

**02/21/2024 - Full**

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/15/2024*

04/25/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/09/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 04/30/2024

05/07/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/09/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission

Follow-Up Date: 05/10/2024

05/30/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 05/09/2024

Reviewer: [REDACTED]

Follow-Up Type: Exception

18 Other laws, regs, ordins.

1. Requirements

2800.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The home is operating two boilers in the basement. Both boiler certificates expired in January 2024:

- Serial number 398812B expired on 1/30/2024

- Serial number 398811B expired on 1/04/2024

Plan of Correction

Accept [REDACTED] 04/24/2024)

Boilers were inspected on 2/22/24 by [REDACTED] from the PA Department of labor and Industry.

Maintenance Director created a calendar on 4/12/24 to maintain all annual inspections for the facility. The calendar will be checked monthly by maintenance director beginning on 4/15/24 to maintain compliance. An audit tool was created and completed by the Executive Director on 4/12/24 for annual inspections.

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented [REDACTED] - 05/30/2024)

51 Criminal background checks

2. Requirements

2800.

51. Criminal background checks

- a. 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).
- b. The hiring policies shall be in accordance with the Department of Aging's Older Adult Protective Services Act policy as posted on the Department of Aging's web site.

Description of Violation

The criminal history background check request, dated [REDACTED]/22, for staff person A, hired [REDACTED]/22, indicates "Request Still Pending Review." The home does not have the final report from the Pennsylvania State Police in accordance with 6 Pa. Code Chapter 15.

Repeat violation: 7/25/23 et al; and 4/4/23, et al

Plan of Correction

Accept [REDACTED] - 05/07/2024)

The final report for staff person A was obtained by "The Home" on 2/23/24.

A sign off will occur by the Administrator on the Onboarding Tracking Form confirming that staff have their criminal history check results prior to the first day of work ensuring that no persons work prior to obtaining. All staff files were audited by the business office manager on 4/10/24.

The Onboarding Tracking Form has been created and will be implemented beginning 4/10/24 for all staff. The Business Office Manager is responsible for maintaining compliance with regulation 2800.51. Weekly auditing will be done by the Business Office Manager/Executive Director beginning 4/15/2024. All staff persons involved in the hiring process will be educated by the Administrator by 4/15/24. Education and audit forms will be available for

51 Criminal background checks (continued)

department review.

Licensee's Proposed Overall Completion Date: 05/06/2024

Implemented [redacted] - 05/30/2024)

54a Direct care staff quals

3. Requirements

2800.

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

Staff person A, hired [redacted]/22, does not have a high school diploma, GED diploma, or active registration status on the Pennsylvania nurse aide registry.

Staff person B, hired [redacted]/24, does not have a high school diploma, GED diploma, or active registration status on the Pennsylvania nurse aide registry.

Repeat violation: 4/4/23 et al

Plan of Correction

Accept [redacted] - 05/07/2024)

Staff person A hired [redacted] 22, does not have a high school diploma, GED diploma, or active registration status on the Pennsylvania nurse aide registry. Staff person A's high school diploma was obtained on 2/24/24. A waiver was requested for Staff Person B utilizing the Request for Waiver of Regulation on 4/15/24. Staff person B was removed from direct care until a waiver is obtained. The Onboarding Tracking Form has been created and will be implemented beginning 4/10/24 for all staff. A sign off will occur by the Administrator on the Onboarding Tracking Form confirming that the "home" has obtained documentation of GED/high school diploma or active registry status on the Pennsylvania nurse aide registry for direct care staff. The Business Office Manager is responsible for maintaining compliance with regulation 2800.54. All staff files were audited for compliance on 4/10/2024. Weekly auditing will be done by the Business Office Manager/Executive Director beginning 4/15/2024. All staff people involved in the hiring process will be educated by the Administrator by 4/15/24. Education and audit forms will be available for department review.

Licensee's Proposed Overall Completion Date: 05/06/2024

Implemented [redacted] - 05/30/2024)

65a Fire Safety-1st day

4. Requirements

2800.

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.

**65a Fire Safety-1st day (continued)**

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.

**Description of Violation**

Staff person C, hired [REDACTED]/23, has not received orientation in any of the required topics in accordance with 2800.65a.

Repeat violation: 4/4/23 et al

**Plan of Correction**

Accept [REDACTED] - 05/07/2024)

Staff person C received fire safety training on 7/8/2023 including all 5 subsections: 1. Evacuation Procedures 2. Staff duties and responsibilities during fire drills as well as during emergency evacuations, transportation and at emergency locations 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 homes smoking policy and location of smoking area. 5. The location and use of fire extinguishers.

All direct care staff will complete orientation within 40 hours of hire date. The Business Office Manager is responsible for maintaining compliance with regulation 2800.65a on a biweekly basis. All staff persons involved in the hiring process will be educated by the Executive Director by 4/15/24. Education will be available for department review.

All files will be reviewed by 4/15/24 by the Business Office Manager. An Onboarding Tracking Form has been created and will be implemented beginning 4/10/24 for all staff. Weekly auditing will be done by the Business Office Manager/Executive Director beginning 4/15/2024. Staff training will be reviewed as part of the residents' quality management plan in an accordance with 2800.26 (a) through 26(c)

Licensee's Proposed Overall Completion Date: 05/06/2024

Implemented [REDACTED] - 05/30/2024)

**65e Rights/Abuse 40 Hours****5. Requirements**

2800.

65.e. 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.
5. Safe management techniques.
6. Core competency training that includes the following:
  - i. Person-centered care.
  - ii. Communication, problem solving and relationship skills.
  - iii. Nutritional support according to resident preference.

**Description of Violation**

On 2/23/24, ancillary staff person C, hired [REDACTED]/23, completed their 40th hour of work in 2023; however, did not

65e Rights/Abuse 40 Hours (continued)

receive orientation training in any of the required topics in accordance with 2800.65e.

Repeat violation: 5/10/23 et al

Plan of Correction

Accept [REDACTED] - 05/07/2024)

Staff person C received their orientation training on 8/8/23, which included 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. 5. Safe management techniques. 6. Core competency training that includes the following: i. Person-centered care. ii. Communication, problem solving and relationship skills. iii. Nutritional support according to resident preference All direct care staff will complete orientation within 40 hours of hire date. The Business Office Manager is responsible for maintaining compliance with regulation 2800.65e on a biweekly basis. All staff persons involved in the hiring process will be educated by the Administrator by 4/15/24. All staff files were audited for compliance on 4/10/2024 by the business office manager. Weekly auditing will be done by the Business Office Manager/Executive Director beginning 4/15/2024. Education and audit forms will be available for department review. Staff training will also be reviewed as part of the residence's quality management plan in accordance with 2800.26(a) through 26(c)

Licensee's Proposed Overall Completion Date: 05/06/2024

Implemented [REDACTED] - 05/30/2024)

69 Dementia training

6. Requirements

2800.

69. Additional Dementia-Specific Training - Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

Description of Violation

Staff person A, hired [REDACTED]/22, and staff person C, hired [REDACTED]/23, did not receive any dementia-specific training within 30 days of hire.

Repeat violation: 4/4/23 et al

Plan of Correction

Accept [REDACTED] /07/2024)

Staff person A received their training on 7/25/23 and Staff person C received their training on 8/8/23, which included at least 4 hours of dementia-specific training. The Business Office Manager is responsible for maintaining compliance with regulation 2800.69. All staff files were audited for compliance on 4/10/2024 by the business office manager. Weekly auditing will be done by the Business Office Manager/Executive Director beginning 4/15/2024. Education and audit forms will be available for department review. Staff training will be reviewed as part of the residents' quality management plan in an accordance with 2800.26 (a) through 26(c)

Licensee's Proposed Overall Completion Date: 05/06/2024

Implemented [REDACTED] - 05/30/2024)

81a Disability accommodation

7. Requirements

2800.

81.a. The residence shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the home and exiting from the residence.

Description of Violation

On 2/21/24, there were no grab bars for the two toilets closest to the sink in the 1st floor women's restroom, across from the business office.

On 2/21/24, there were no grab bars for the two toilets closest to the entry door in the 1st floor women's common restroom, across from the activity room.

Plan of Correction

Accept [redacted] - 05/07/2024)

Grab bars were installed on 4/24/24 for the two toilets closest to the entry door in the 1st floor women's common restroom, across from the activity room and the women's restroom across from the business office. All restrooms have been checked to by the Maintenance Director for proper accommodations.

Licensee's Proposed Overall Completion Date: 05/06/2024

Implemented [redacted] 05/30/2024)

81b Resident equip – good repair

8. Requirements

2800.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 2/23/24, the two half bed rails on resident #1's bed were not well-secured and could be moved approximately 1" in both directions. There was also an approximate 1" gap between the mattress and the bed rail on the left side of the bed, posing an entrapment/fall hazard.

On 2/23/24, the half bed rail on the right side of resident #2's bed was not well-secured and could be moved approximately 1" in both directions, posing an entrapment/fall hazard.

Plan of Correction

Accept [redacted] - 05/07/2024)

Resident #1's bed rails were removed from the bed on 4/10/2024 by the maintenance director. All bedrails were checked for compliance on 4/10/24 by the Maintenance Director or removed if appropriate. Staff education will be completed on 4/30/24 by the Maintenance Director and will be available for department review. Maintenance Director created a monthly checklist for all beds and bedrails on 4/9/2024. The checklist will be done monthly by the maintenance director beginning on 4/15/24 to maintain compliance.

Licensee's Proposed Overall Completion Date: 05/06/2024

Implemented [redacted] - 05/30/2024)

85a Sanitary conditions

9. Requirements

2800.  
85.a. Sanitary conditions shall be maintained.

Description of Violation

*On 2/23/24 at 10:07 a.m., there were no paper towels, mechanical air blower, individual cloth towels or other means of safe hand drying in the women's bathroom across from the business office.*

Plan of Correction

Accepted (redacted) 04/25/2024)

*On 2/23/24 at 10:07 a.m., there were no paper towels, mechanical air blower, individual cloth towels or other means of safe hand drying in the women's bathroom across from the business office.*

*Paper towels were placed in the bathroom across from the business office on 2/23/24 by housekeeping staff. All common area bathrooms were checked on 2/23/24. Housekeeping staff was reeducated by Executive Director on 2/26/24. Beginning 4/8/24 Maintenance Director or housekeeping staff will check all bathrooms daily to ensure proper stocking of all supplies.*

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented (redacted) - 05/30/2024)

97 Elevator certificate

10. Requirements

2800.  
97. Elevators and Stair Glides - Each elevator and stair glide must have a certificate of operation from the Department of Labor and Industry or the appropriate local building authority in accordance with 34 Pa. Code Chapter 405 (relating to elevators and other lifting devices).

Description of Violation

*The home has 2 elevators. The certificate of operation for unit #002, from the PA Department of Labor & Industry, expired 10/31/23. There is no certificate of operation for the second elevator from the Department of Labor and Industry or appropriate local building authority in accordance with 34 Pa. Code Chapter 405 (relating to elevators and other lifting devices).*

Plan of Correction

Accepted (redacted) - 05/07/2024)

*Elevators were inspected on 3/6/2024 by (redacted). Maintenance Director created a calendar on 4/12/24 to maintain all annual inspections for the facility. Calendar will be checked monthly by maintenance director beginning on 4/15/24 to maintain compliance. An audit tool was created and completed by the Executive Director on 4/12/24 for annual inspections. Inspection certificates are available to the Department upon request.*

Licensee's Proposed Overall Completion Date: 05/06/2024

Implemented (redacted) - 05/30/2024)

101j5 Bedside table/shelf

11. Requirements

2800.  
101.j. Each resident shall have the following in the living unit:  
5. A bedside table or a shelf.

101j5 Bedside table/shelf (continued)

Description of Violation

On 2/23/24, there was no bedside table or shelf beside resident #3's bed in living unit 603.

Repeat violation: 4/4/23 et al

Plan of Correction

Accept [redacted] 04/25/2024)

Bedside table was placed next to resident #3's bed in living unit 603 on 2/23/24. All rooms were checked by Executive Director on 2/26/24 for a bedside table or shelf. Reeducation will be completed by Executive Director by 4/15/24 for all staff regarding bedside tables.

The monthly checklist has been increased to weekly to check for placement of bedside table or shelf by new maintenance director effective 4/12/24.

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented [redacted] - 05/30/2024)

101j7 Lighting/operable lamp

12. Requirements

2800.

101.j. Each resident shall have the following in the living unit:

- 7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 2/21/24, the bed belonging to resident #2 in living unit 213 did not have a source of lighting that could be turned on/off from bedside.

On 2/21/24, the bed belonging to resident #3 in living unit 603 did not have a source of lighting that could be turned on/off from bedside.

On 2/21/24, the bed belonging to resident #4 in living unit 203 did not have a source of lighting that could be turned on/off from bedside.

Plan of Correction

Accept [redacted] - 05/07/2024)

Rooms 203,213 and 603 were checked on 4/10/24 by the Maintenance Director and all 3 have a source of lighting that could be turned on/off from bedside. All rooms were checked to ensure that they have a source of lighting that could be turned on/off from bedside by Maintenance Director on 4/10/24. All rooms will be checked monthly by Maintenance Director to ensure that they have a source of lighting that could be turned on/off from bedside. Direct Care staff has been educated by the DON on 4/30/24 on the requirement and for them to monitor daily as a part of their regular duties. Education will be maintained for department review.

Licensee's Proposed Overall Completion Date: 05/06/2024

101j7 Lighting/operable lamp (continued)

Implemented [redacted] - 05/30/2024)

103d Storing food off the floor

13. Requirements

2800.  
103.d. Food shall be stored off the floor.

Description of Violation

On 2/21/24, there was a large piece of chicken wrapped in foil on a metal tray stored on the floor inside the walk-in freezer located in the kitchen.

Plan of Correction

Accept [redacted] 05/07/2024)

Metal Tray was removed from the walk-in freezer floor on 2/21/24 by Culinary Director. All kitchen staff were re-educated on proper food storage on 4/12/24 by the Executive Director. Kitchen rounds checklist was created on 4/12/24 by executive director and will be completed weekly by Culinary Director or Designee beginning 4/12/24. The Executive Director will monitor compliance monthly.

Licensee's Proposed Overall Completion Date: 05/06/2024

Implemented [redacted] - 05/30/2024)

103g Storing food

14. Requirements

2800.  
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 2/21/24, there was torn plastic bag of hot dogs, an unsealed 1/2 pound of butter and an uncovered container of turkey base in the stand-up breakfast cooler located in the kitchen.

On 2/21/24, there was an unsealed single serve container of Magic Cup frozen dessert in the freezer located in the special care unit (SCU).

Repeat violation: 4/4/23 et al

Plan of Correction

Accept [redacted] 05/07/2024)

All food was removed and thrown in the trash on 2/21/24 by the Executive Director. All kitchen staff were reeducated on proper food storage on 4/12/24 by the Executive Director. Education will be available for review. Kitchen rounds checklist was created on 4/12/24 by executive director and will be completed daily by Culinary Director or Designee beginning 4/12/24. The Executive Director will monitor compliance monthly.

Licensee's Proposed Overall Completion Date: 05/06/2024

Implemented [redacted] - 05/30/2024)

103i Outdated food

15. Requirements

2800.

103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 2/21/24, the following foods were undated and unsealed in the stand-up freezer in the kitchen:

-Box of hamburger patties

-Box of country fried steaks

Plan of Correction

Accepted [redacted] - 05/07/2024)

All food was removed and thrown in the trash on 2/21/24 by the Executive Director. All kitchen staff were reeducated on proper food storage on 4/12/24 by the Executive Director. Kitchen rounds checklist was created on 4/12/24 by executive director and will be completed weekly by Culinary Director or Designee beginning 4/12/24. The Executive Director will monitor for compliance monthly.

Licensee's Proposed Overall Completion Date: 05/06/2024

Implemented [redacted] - 05/30/2024)

132c Fire drill records

16. Requirements

2800.

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 residence 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 fire drill log for the drill conducted on 11/27/23 does not indicate which exit routes were used.

The fire drill log for the fire drill conducted on 12/13/23 indicates that 39 of 48 residents were evacuated; however, there were only 39 residents in the residence. The log includes 9 of the residents who reside on the independent living floors of the home.

Repeat violation: 4/4/23 et al

Plan of Correction

Accepted [redacted] - 05/07/2024)

On 2/23/24 exit route was added to the fire drill log for 11/27/23 by executive director. On 2/23/24 the fire drill log for 12/13/24 has been adjusted by the executive director to reflect only assisted living residents. An audit of all fire drills was completed on 2/26/24 by executive director. All staff responsible for conducting fire drills were educated on the proper fire drill reporting and procedures on 4/12/24 by executive director. Executive Director and Maintenance Director will review monthly starting on 4/15/24 fire drill records to include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the residence 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. These reviews will take place during our monthly safety meetings. The Executive

132c Fire drill records (continued)

Director will observe the May and June fire drills and the completion of the fire drill log to ensure it is completed accurately and in its entirety.

Licensee's Proposed Overall Completion Date: 05/06/2024

Implemented [redacted] - 05/30/2024)

132d Evacuation

17. Requirements

2800.

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 residence.

Description of Violation

Five minutes is the maximum safe evacuation time specified in writing within the past year by a fire safety expert on 5/10/2023. The residence exceeded that maximum safe evacuation time during fire drills on the following dates:

<u>Date &amp; time of fire drill</u>	<u>Evacuation Time</u>
6/1/23 8:10 am	6 minutes
7/12/23 8:20 am	5 minutes, 1 second
8/9/23 8:15 am	5 minutes, 16 seconds
9/13/23 at 8:30 am	8 minutes, 46 seconds
11/27/23 3:39 pm	8 minutes, 16 seconds
12/13/23 5:00 am	15 minutes, 26 seconds.

Repeat violation: 4/4/2023 et al

Plan of Correction

Accept [redacted] 05/07/2024)

The Ross Township fire marshal will determine in writing the maximum safe evacuation time during fire drills for the residence on 4/15/24. Once determined the executive director will educate all staff on the proper evacuation time frames and the proper procedures for future fire drills by 4/30/24. Monthly fire drills will be reviewed by Executive Director and Maintenance Director starting on 4/15/24. Fire drill records will ensure that the 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 specified in writing within the past year by a fire safety expert. The ED/administrator to observe the May and June fire drills to ensure all residents evacuate to the fire safe areas in the time designated in writing by the fire safety expert.

Licensee's Proposed Overall Completion Date: 05/06/2024

Implemented [redacted] - 05/30/2024)

132e Fire drill - sleeping hours

18. Requirements

132e Fire drill - sleeping hours (continued)

2800.

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

Description of Violation

Seven months elapsed between the sleeping hours fire drill conducted on 5/10/23 at 5:22 a.m. and the drill conducted on 12/13/23 at 5:00 a.m.

Repeat violation: 4/4/23 et al

Plan of Correction

Accepted [redacted] - 05/07/2024)

A fire drill during sleeping hours will be conducted on 5/9/2024 at 5am by the Maintenance Director. New maintenance director has been educated on 2800.132e that a fire drill shall be held during sleeping hours once every 6 months by Executive Director on 4/12/24. Monthly fire drills will be reviewed by Executive Director and Maintenance Director starting on 4/15/24. The ED/administrator to observe the May and June fire drills to ensure all procedures are followed.

Licensee's Proposed Overall Completion Date: 05/06/2024

Implemented [redacted] - 05/30/2024)

132g Fire drills – days/times

19. Requirements

2800.

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 fire drills from June to October 2023 were conducted between 8:00 a.m. and 8:30 a.m., as follows:

6/14/23 at 8:10am

7/12/23 at 8:20am

8/9/23 at 8:25am

9/13/23 at 8:30am

10/11/23 at 8:15am

Plan of Correction

Accepted [redacted] - 05/07/2024)

The Ross Township fire Marshal will conduct a fire drill at 10am on 4/15/24. New Maintenance Director was educated on 4/12/24 by the executive director that 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. Monthly fire drills will be reviewed by Executive Director and Maintenance Director starting on 4/15/24. The ED/administrator to monitor the May and June fire drills to ensure all procedures are followed.

Licensee's Proposed Overall Completion Date: 05/06/2024

Implemented [redacted] - 05/30/2024)

171b5 Transportation-first aid kit

**20. Requirements**

2800.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2800.96 (relating to first aid kit). The inclusion of an automatic external defibrillation device in a vehicle is optional.

**Description of Violation**

*On 2/23/24, the first aid kit in the van used to transport residents did not include a thermometer, eye coverings and tweezers.*

**Plan of Correction****Accept** [REDACTED] - 04/25/2024)

*The first aid kit in the van used to transport residents was corrected on 4/8/24 by the activities director to include a thermometer, eye coverings and tweezers. All staff responsible for driving the van were reeducated by the executive director on what items belong in the first aid kit on 4/12/24. Monthly audits of the van first aid kit will be added by the activities director beginning on 4/15/ 24.*

**Licensee's Proposed Overall Completion Date: 04/15/2024**

**Implemented** [REDACTED] - 05/30/2024)**184a Resident meds labeled****21. Requirements**

2800.

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 #6 is ordered Eliquis 5mg, 1 tablet twice a day. Two medication bottles are present in the residence, one for morning and one for evening; however, there is no label on the evening bottle.*

*Repeat violation: 11/21/23 et al, 8/9/23 et al; and 4/4/23, et al*

**Plan of Correction****Accept** [REDACTED] - 05/07/2024)

*In meeting immediate corrective action, RN/DON removed the bottle of Eliquis medication without appropriate label on 2/21/24. A new bottle of Eliquis with the appropriate label was obtained from the provider and placed into the medication cart by RN/DON on 2/21/24. RN/DON will perform re-education and in-service with staff regarding the following regulation: 2800.184.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. Education for staff will demonstrate that if a medication is found to be mislabeled or missing portions/all of label, that medication should be removed from the treatment area, the RN/DON should be immediately notified, and the pharmacy should be notified to supply medication with proper labeling. This training will be done by the RN/DON and given to all medication technicians and LPN by 4/15/24. RN/DON is responsible for performing*

**184a Resident meds labeled (continued)**

weekly audits going forward to assure medication labels are all appropriate to fulfill order and regulatory requirements. Weekly audits will be available for department review All labels have been checked and verified by RN/DON to have appropriate labeling that meets the regulation listed on 4/8/24.

Licensee's Proposed Overall Completion Date: 05/06/2024

Implemented [REDACTED] - 05/30/2024)

**185a Storage procedures****22. Requirements**

2800.

185.a. The residence 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**

On 2/21/24, resident #5's glucometer was not calibrated to the current date and time.

On 2/21/24, resident #7's glucometer was not calibrated to the current date and time.

**Plan of Correction**

Accept [REDACTED] - 04/25/2024)

In meeting immediate corrective action, RN/DON calibrated all glucometers to correct date and time on 2/21/24. All medication technicians and LPN will be retrained on glucometer calibration by 4/15/24 by RN/DON. The training demonstrated includes how to verify appropriate date and time calibration on a glucometer, how to re-calibrate the glucometer if necessary, and to report any concerns with calibrated equipment to RN/DON. The following regulation is included in the retraining:

2800.185.a. The residence shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

RN/DON is responsible for monitoring compliance of calibrated equipment. This will be completed by RN/DON during the weekly audits starting on 4/8/24 for 3 months, and monthly thereafter, to assure calibration fulfills regulatory requirements.

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented [REDACTED] - 05/30/2024)

**203 Bedside rails****23. Requirements**

2800.

203. Bedside Rails

- a. Bedside rails may not be used unless the resident can raise and lower the rails on his own. Bedside rails may not be used to keep a resident in bed. Use of any length rail longer than half the length of the bed is considered a restraint and is prohibited. Use of more than one rail on the same side of the bed is not permitted.
- b. Half-length rails are permitted only if the following conditions are met:
  1. The resident's assessment or support plan, or both, addresses the medical symptoms necessitating the use of half-length rails and the health and safety protection necessary in order to safely use half-length rails.
  2. The residence has attempted to use less restrictive alternatives.

203 Bedside rails (*continued*)

3. The resident or legal representative consented to the use of half-length rails after the risk, benefits and alternatives were explained.

**Description of Violation**

*On 2/23/24, half-length rails were used on both sides of resident #1's bed.*

*-Resident #1 is unable to raise and lower the rails on [REDACTED]r own.*

*-The assessment and support plan for resident #1, dated [REDACTED] 23, do not address the medical symptoms necessitating the use of half-length rails and the health and safety protection necessary in order to safely use half-length rails. Also, the resident is unable to raise and lower the bedrails independently.*

**Plan of Correction**

**Accept [REDACTED] 05/07/2024)**

*On 4/8/24, Maintenance Director removed the bed rails from the bed in resident #1's room. On 4/8/24, RN/DON conducted audits for all siderails presently being used to determine they meet the following regulatory criteria 2800.203. Bedside Rails a. Bedside rails may not be used unless the resident can raise and lower the rails on [REDACTED] own. Bedside rails may not be used to keep a resident in bed. Use of any length rail longer than half the length of the bed is considered a restraint and is prohibited. Use of more than one rail on the same side of the bed is not permitted.*

*b. Half-length rails are permitted only if the following conditions are met:*

- 1. The resident's assessment or support plan, or both, addresses the medical symptoms necessitating the use of half-length rails and the health and safety protection necessary in order to safely use half-length rails.*
- 2. The residence has attempted to use less restrictive alternatives.*
- 3. The resident or legal representative consented to the use of half-length rails after the risk, benefits and alternatives were explained.*

*All bedrails were checked for compliance on 4/10/24 by the Maintenance Director. The Maintenance Director will check each resident's room and equipment, particularly residents with mobility needs, to ensure that there is no use of restraints, including mechanical restraints.*

*The Administrator will monitor each resident with a bedrail or other bedside mobility device bi-weekly to ensure bedrails are used according to all the Department's regulations for bedrail safety, including having openings covered. Maintenance Director created a monthly checklist for all beds and bedrails on 4/9/2024. The checklist will be done monthly by the maintenance director beginning on 4/15/24 to maintain compliance.*

*The Administrator will review the Department's policy on bedrails and bedside mobility devices to ensure the residence is meeting the Department's compliance standards by 4/30/24.*

*Within 30 calendar days of receipt of the plan of correction – All staff will be educated on the prohibition of the use of resident restraints, including mechanical restraints such as bedrails. Education shall also include the risks of bedrail/bedside mobility devices such as strangulation, suffocation and other injuries. Staff will be instructed to immediately report to the administrator the use of any restraints ordered and/or provided by outside medical providers such as a physical therapist or physician. Documentation of training and audits will be kept for department review.*

203 Bedside rails (continued)

Licensee's Proposed Overall Completion Date: 05/06/2024

Implemented ( ) 05/30/2024)

225b Assessment content

24. Requirements

2800.

225.b. The assessment must, at a minimum include the following:

1. The resident's need for assistance with ADLs and IADLs.
2. The mobility needs of the resident.
3. The ability of the resident to self-administer medication.
4. The resident's medical history, medical conditions, and current medical status and how these impact or interact with the individual's service needs.
5. The resident's need for supplemental health care services.
6. The resident's need for special diet or meal requirements.

Description of Violation

The assessment, dated ( ) 3, for resident #1 does not include the diagnoses of history of falls and muscle weakness that are indicated on the medical evaluation, dated ( )/23.

Plan of Correction

Accept ( ) 04/25/2024)

Assessment for resident #1 was updated on 2/23/24 by the PCP, ( ) to include the diagnoses of history of falls and muscle weakness. All resident assessments will be audited by DON by 4/30/24. All staff completing resident support plans will be reeducated by Area Operations Director on 4/13/24. All resident support plans will be audited by DON by 4/30/24. Monthly audits of new resident support plans will be completed by the Executive Director beginning on 5/1/2024.

Licensee's Proposed Overall Completion Date: 04/30/2024

Implemented ( ) - 05/30/2024)

227d Support plan – med/dental

25. Requirements

2800.

227.d. Each residence shall document in the resident's final support plan the dietary, medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

Description of Violation

The support plan, dated 9/26/23, for resident #1, does not indicate how the home will meet the resident's needs related to transferring in/out of bed/chair, ambulating, personal hygiene, managing health care, securing health care, turning and positioning in bed/chair, doing laundry, shopping, securing and using transportation, managing finances, using the telephone, making and keeping appointments, caring for personal possessions, engaging in social and leisure activities, obtaining clean, seasonal clothing, orientation to time, place and person, judgment, agitation, understanding instructions, long term memory, and ability to avoid poisonous materials, as indicated on the assessment, dated 9/26/23. The support plan is blank in these areas.

227d Support plan – med/dental (continued)

Plan of Correction

Accept [redacted] /25/2024)

Support plan for resident #1 was updated on 2/23/24 by the DON to include how the home will meet the resident's needs related to transferring in/out of bed/chair, ambulating, personal hygiene, managing health care, securing health care, turning and positioning in bed/chair, doing laundry, shopping, securing and using transportation, managing finances, using the telephone, making and keeping appointments, caring for personal possessions, engaging in social and leisure activities, obtaining clean, seasonal clothing, orientation to time, place and person, judgment, agitation, understanding instructions, long term memory, and ability to avoid poisonous materials. All staff completing resident support plans will be reeducated by Area Operations Director on 4/13/24. All resident support plans will be audited by DON by 4/30/24. Monthly audits of new resident support plans will be completed by the Executive Director beginning on 5/1/2024.

Licensee's Proposed Overall Completion Date: 04/30/2024

Implemented [redacted] - 05/30/2024)

233c Key-locking devices

26. Requirements

2800.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On 2/21/23, there was no code posted for the locking mechanism for the stairwell exit door next to unit 212.

Plan of Correction

Accept [redacted] - 04/25/2024)

The code for the locking mechanism was placed by the exit door next to unit 212 on 2/21/24 by Executive Director. All staff will be reeducated by 4/15/24 by the Executive Director regarding the posting of the code for the locking mechanisms. Monthly audits will be done by the maintenance director beginning on 4/15/24 to maintain compliance.

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented [redacted] - 05/30/2024)

251b Record entries - legible

27. Requirements

2800.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on the top portion of the first page of resident #2's contract, dated [redacted] /23, and the resident's name was written over it. Correction fluid was also used following the responsible party section of the acknowledgement and awareness of the resident residing on the secured floor of the home and the resident's signature was written over it.

Plan of Correction

Accept [redacted] 04/25/2024)

Resident #2's contract dated [redacted] /23 was corrected by Business Office Manager on 2/21/24. All resident files will be checked for the usage of correction fluid by 4/15/24. The Business Office Manager is responsible for maintaining compliance with regulation 2800.251b. All staff persons involved in the admissions process will be educated by the

*251b Record entries - legible (continued)*

*Administrator by 4/15/24. Weekly auditing will be done by the Business Office Manager/Executive Director beginning 4/15/2024. Education will be available for department review.*

**Licensee's Proposed Overall Completion Date: 04/15/2024**

**Implemented [REDACTED] - 05/30/2024)**

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

**Facility Information**

Name: *NORTHLAND HEIGHTS* License #: *45084* License Expiration: *05/03/2024*  
Address: *4859 MCKNIGHT ROAD, PITTSBURGH, PA 15237*  
County: *ALLEGHENY* Region: *WESTERN*

**Administrator**

Name: [REDACTED]

**Legal Entity**

Name: *NORTHLAND HEIGHTS LLC*

Address: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-1* Date: *01/21/2020* Issued By: *Ross Township*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *60* Waking Staff: *45*

**Inspection Information**

Type: *Partial* Notice: *Unannounced* BHA Docket #:  
Reason: *Provisional, Incident* Exit Conference Date: *04/10/2024*

**Inspection Dates and Department Representative**

03/27/2024 - On-Site: [REDACTED]  
04/08/2024 - Off-Site: [REDACTED]  
04/10/2024 - Off-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *123* Residents Served: *38*

**Special Care Unit**

In Home: *Yes* Area: *SCU* Capacity: *19* Residents Served: *7*

**Hospice**

Current Residents: *4*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *38*  
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *1*  
Have Mobility Need: *22* Have Physical Disability: *1*

Inspections / Reviews

03/27/2024 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *05/02/2024*

05/10/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *05/13/2024*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: *05/13/2024*

05/30/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *05/13/2024*

Reviewer: [REDACTED]

Follow-Up Type: *Exception*

## 15a Resident abuse report

### 1. Requirements

2800.

15.a. The residence shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

### Description of Violation

On 14/24, at approximately 11:00 a.m., staff person A was told that, during the previous night, a staff person covered resident #1's mouth, put covers on over the resident's face and said the resident talks too much. This allegation of abuse was not reported to the local area agency on aging until 3/15/24 at approximately 9:00 p.m.

Repeat Violation: 7/25/23 et al

### Plan of Correction

Accept [REDACTED] - 05/07/2024)

Staff person A was immediately educated to report suspected abuse of a resident by verbally reporting to immediate supervisor or to APS by DON on 3/15/24.

All staff re-educated on reporting suspected abuse of a resident immediately by verbally reporting to immediate supervisor or calling APS by ED by 3/19/24. All management staff re-educated to report suspected abuse to APS within 24 hours of notification by ED by 5/10/24. DON or Manager on Duty will review 24 hour nursing reports daily to monitor for written reports of suspected abuse. DON educated to review 24 hour reports daily by ED by 3/19/24. All managers educated to review 24 hour reports for written reports of suspected abuse in absence of DON on by 3/19/24.

All trainings will be maintained for verification and review by licensing staff upon request.

Suspected abuse reporting and training to be reviewed at Quality Management meetings.

Licensee's Proposed Overall Completion Date: 05/10/2024

Implemented [REDACTED] - 05/21/2024)

## 16c Incident reporting

### 2. Requirements

2800.

16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

### Description of Violation

14/24, at approximately 11:00 a.m., staff person A was told that, during the previous night, a staff person covered resident #1's mouth, put covers on over the resident's face and said the resident talks too much. The residence did not report this incident to the Department until 3/15/24 at 9:00 p.m.

Repeat Violation: 4/4/23 et al and 5/10/23 et al

### Plan of Correction

Accept [REDACTED] D - 05/07/2024)

Staff person A educated to report suspected abuse of a resident by verbally reporting to immediate supervisor or to DHS by DON on 3/19/24.

16c Incident reporting (continued)

All staff re-educated on reporting suspected abuse of a resident immediately by verbally reporting to immediate supervisor or calling DHS by ED on 3/19/24. All management staff re-educated to report suspected abuse to DHS within 24 hours of notification by ED on 3/19/24. DON or Manager on Duty will review 24 hour nursing reports daily to monitor for written reports of suspected abuse. DON educated to review 24 hour reports daily by ED on 3/19/24. All managers educated to review 24 hour reports for written reports of suspected abuse in absence of DON on by 3/19/24.

All trainings will be maintained for verification and review by licensing staff upon request. Suspected abuse reporting and training to be reviewed at Quality Management meetings.

Licensee's Proposed Overall Completion Date: 05/10/2024

Implemented [redacted] - 05/21/2024)

17 Record confidentiality

3. Requirements

2800.

17. Confidentiality of Records - 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

On 3/27/24, at 2:32 p.m., Room number 225, located on the second-floor nurses' station, contained numerous resident record's that were unlocked, unattended, and accessible.

Repeat Violation: 4/4/23 et al

Plan of Correction

Accept [redacted] 05/07/2024)

All staff re-educated to keep resident records confidential and to keep room number 225 closed and locked when unattended at all times by ED on 3/19/24.

ED or Manager on Duty will make rounds daily to audit for compliance beginning 5/6/24 for 2 months.

All training and audit will be maintained for verification and review by licensing staff upon request.

Licensee's Proposed Overall Completion Date: 05/10/2024

Implemented [redacted] 05/21/2024)

42b Abuse/Neglect

4. Requirements

2800.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted]/24, during the evening hours after 7:00 p.m., resident #1 was lying in bed. Resident #1 has a vision impairment. An unidentified [redacted] staff person entered resident #1's room. The staff person covered the resident's put their hands on the resident's face, near [redacted] mouth, causing an abrasion to [redacted] right side of [redacted] mouth. Resident #1 was startled and pushed the hand away from [redacted] face, and cried out "Why are you trying to muffle me?" The

**42b Abuse/Neglect (continued)**

staff person put the covers over the resident's face and said in a loud voice, "Because you talk too much." Resident #1 felt scared and confuse and the staff person abruptly left the resident's room.

Repeat Violation: 7/25/23 et al and 5/10/23 et al

**Plan of Correction**

Directed [REDACTED] - 05/10/2024)

Facility disputes this violation.

Resident #1's allegation was reported to the Department of Aging and investigated by Protective Services. The allegation was unfounded and unsubstantiated on 4/10/24, following their investigation. There have been three additional abuse allegations made by Resident #1, since this occurrence, who has a vision impairment and is diagnosed with dementia, and not noted in this POC. All have been unsubstantiated as of 5/1/24. Additionally, there was no staff member identified in the facility investigation or any investigations completed by DHS/BHSL or Protective Services.

The facility immediately put in place a two-caregiver requirement for Resident #1's care. DON is pursuing an order for a psychiatric consult. ED has discussed the need for Resident #1 to move to the onsite Memory Care Unit with family and is awaiting needed information from the family.

Staff training on Dementia Care with Challenging Behaviors was initiated for staff on 5/1/24 and is to be completed by 5/31/24.

**DIRECTED:** Within 30 calendar days of receipt of the plan of correction: The home will conduct a quality management plan review and evaluation. The Administrator will place an increased emphasis on these plans of correction and take action to improve the quality of its resident rights and Older Adult Protective Services Act (OAPSA) training for all newly hired staff within 40 scheduled working hours in accordance with §2600.65(b)(1) and §2600.65(b)(3) and annually in accordance with §2600.65(g)(3) and §2600.65(g)(4). - [REDACTED] 5/25/24

Directed Completion Date: 06/30/2024

Implemented [REDACTED] - 05/21/2024)

**187d Follow prescriber's orders****5. Requirements**

2800.

187.d. The home shall follow the directions of the prescriber.

**Description of Violation**

Resident #1 is prescribed Lisinopril 5MG TABS VBM give one tablet by mouth once daily at 8:00 a.m. However, this medication was not administered to resident # 1 on 3/1, 3/2,3/3 and 3/4/24 because the medication was not available in the residence.

Resident #1 is prescribed Melatonin 3 MG TABS give 2 tablets (6MG) by mouth at bedtime. However, this medication was not administered to resident #1 on 3/1,3/2 and 3/3/24 because the medication was not available in the residence.

Resident #1 is prescribed Lorazepam 1 MG TAB Give 1/2 tablet by mouth twice a day at 8:00 a.m. and 8:00 p.m. However, this medication was not administered to resident #1 on 3/17/24 at 8:00 p.m. and 3/18/24 at 8:00 a.m. because the medication was not available in the residence.

Repeat Violation: 5/10/23, et al. 8/9/23, et al.

187d Follow prescriber's orders (continued)

**Plan of Correction**

**Accept** [REDACTED] - 05/07/2024)

*Resident #1 has medication from an outside pharmacy with delivery by [REDACTED] DON audited Resident #1's medication to confirm all current prescribed medications are available on 3/19/24. DON, LPNs and Med Techs re-educated to contact family two weeks prior of medication depletion to obtain refill from preferred outside pharmacy and to obtain medication from house pharmacy if not delivered timely. DON will audit medications for all residents weekly beginning 4/9/24 to confirm all medications are available in the residence. Pharmacy was notified, educated, and confirmed receipt of the violation on 5/2/24 by ED. All trainings and audits will be maintained for verification and review by licensing staff upon request.*

**Licensee's Proposed Overall Completion Date:** 05/10/2024

**Implemented** [REDACTED] - 05/21/2024)

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

**Facility Information**

Name: *NORTHLAND HEIGHTS* License #: *45084* License Expiration: *05/03/2024*  
Address: *4859 MCKNIGHT ROAD, PITTSBURGH, PA 15237*  
County: *ALLEGHENY* Region: *WESTERN*

**Administrator**

Name: [REDACTED]

**Legal Entity**

Name: *NORTHLAND HEIGHTS LLC*  
Address: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-1* Date: *01/21/2020* Issued By: *Ross Township*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *49* Waking Staff: *37*

**Inspection Information**

Type: *Partial* Notice: *Unannounced* BHA Docket #:  
Reason: *Incident, Monitoring* Exit Conference Date: *05/24/2024*

**Inspection Dates and Department Representative**

05/13/2024 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *123* Residents Served: *35*

**Special Care Unit**

In Home: *Yes* Area: *2nd Floor* Capacity: *18* Residents Served: *7*

**Hospice**

Current Residents: *3*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *35*  
Diagnosed with Mental Illness: *2* Diagnosed with Intellectual Disability: *2*  
Have Mobility Need: *14* Have Physical Disability: *2*

**Inspections / Reviews**

05/13/2024 - Partial

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

**NO DEFICIENCIES FOUND**