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

April 10, 2024

[redacted], OWNER
P.A.L., INC.
122 RIDGEVIEW STREET
YOUNGWOOD, PA, 15697

RE: RIDGEVIEW RESIDENTIAL CARE
122 RIDGEVIEW STREET
YOUNGWOOD, PA, 15697
LICENSE/COC#: 42858

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/23/2024 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: *RIDGEVIEW RESIDENTIAL CARE* **License #**: *42858* **License Expiration**: *11/06/2024*

Address: *122 RIDGEVIEW STREET, YOUNGWOOD, PA 15697*

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

Administrator

Name: [redacted]

Legal Entity

Name: *P.A.L., INC.*

Address: *122 RIDGEVIEW STREET, YOUNGWOOD, PA, 15697*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/18/1999* **Issued By**: *Dept L & I*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *02/23/2024*

Inspection Dates and Department Representative

02/23/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *40* **Residents Served**: *32*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *32*

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

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

Inspections / Reviews

02/23/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/21/2024*

03/18/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/10/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/25/2024*

Inspections / Reviews *(continued)*

04/03/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/10/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/12/2024*

04/10/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/10/2024*

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

65g Annual Training Content

1. 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:

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.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person A, hired on [redacted], did not receive the required training on the topic fire safety completed by a fire safety exit for the 2023 training year.

Plan of Correction ***[redacted] - 03/19/2024)***

On 2/26/2024 the Administrator requested and received a copy of staff member A fire safety training from [redacted] other employer at the [redacted] center which [redacted] attended 8/31/2023.
Ridgeview Residential Care next staff fire safety meeting will be on 5/6/2024 at 9am & 1pm given by Johnstown safety services ([redacted]).
New staff hired after this time or staff unable to make the 5/6/2024 class will be required to do an online class approved by our fire safety expert (Johnstown safety services) and will be monitored by the Administrator, or Administrator Assistant.

Licensee's Proposed Overall Completion Date: *04/03/2024*

Implemented [redacted] - 04/10/2024)

81b Resident Personal Equipment

2. Requirements

2600.
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

The bed enabler, on resident #1's bed, has an opening on the top portion, measuring approximately 11.5 " x 13.5". The enable bar also has a gap of 1.5" between the mattress and the bed, posing an entrapment hazard.

The bed enable, on resident #2's bed, is not secured allowing the enabler to shift leaving a gap approximately 6" between the enabler and the bed, posing an entrapment hazard.

The bed enable, on resident #3's bed, has an opening on the top portion, measuring approximately 11" x 7". The enable bar also is not secured to the bed, posing an entrapment hazard.

Plan of Correction ***Accept [redacted] - 03/19/2024)***

On 3/1/2024 Resident 1 bed enabler was changed by maintenance to a new one with a secure bag that is mesh

81b - Resident Personal Equipment (continued)

and does not allow for any gaps larger than4".
On 3/1/2024 Resident 2 had another bolt put in by maintenance to ensure that it no longer moves further from the mattress than the required 4" and was also secured to the box spring.
On 3/1/2024 Resident 3 had her mesh bag moved up and secured by maintenance so that it's in compliance. Bed enabler has also been secured to the box spring to prevent any unnecessary movement.
The Administrator or Administrator Assistant will do routine monthly checks starting on 3/1/2024 to ensure bed enablers are in compliance and secure to the beds. Staff have been made aware of the importance of this and any concerns to report to administration immediately. Moving forward, any new residents requiring an enabler will be made aware of department regulations. If family brings an enabler in it will have to go through administrator or administrator assistant, for approval and given to the head of maintenance to put on so it is secured properly.

Licensee's Proposed Overall Completion Date: *04/03/2024*

Implemented ([redacted] - 04/10/2024)

88a - Surfaces

3. 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

The emergency exit door, labeled #6, does not self close.

Plan of Correction ***Directed [redacted] - 04/03/2024)***

Completed on 2/23/2024 Maintenance adjusted exit door #6. Starting March 1, 2024, door checks will be added to the monthly maintenance check list. The head of maintenance will check and advise the Administrator or the Administrator Assistant of any issues.

Directed:
Within 7 days of receipt of the accepted plan of correction the administrator or designated staff person shall begin monthly inspections of the facility to identify any maintenance concerns.
[redacted]. 4/3/24

Proposed Overall Completion Date: 03/18/2024

Directed Completion Date: *04/12/2024*

Implemented [redacted] - 04/10/2024)

102l - Shelves/Hooks

4. Requirements

2600.
102.l. Shelves or hooks for the resident's towel and clothing shall be provided.

Description of Violation

There was only one towel rack in the private bathroom, shared by resident #4 and resident #5. Additionally, the towel rack was not labeled.

102l - Shelves/Hooks (continued)

Two hooks are hanging on the door in the private bathroom, shared by 2 residents, to include resident #6; however, the hooks were not labeled.

Plan of Correction ***Accept ([redacted] - 04/03/2024)***

Completed by the Administrator on 2/23/2024: Name labels were added to the towel rack in shared room by Resident #4 and Resident #5. Starting 3/1/2024 upon new admission labels will be added in shared bathrooms by the administrator. The Administrator or Administrator Assistant will check new residents during the admission process.
Completed by the Administrator on 2/23/2024: Name labels were added to the hooks on the door in the private bathroom shared by two residents, included Resident # 6. Starting 3/1/2024, upon new admission labels will be added in private bathrooms shared by two by the administrator. Administrator or Administrator Assistant will check new residents during the admission process.

Licensee's Proposed Overall Completion Date: *04/03/2024*

Implemented ([redacted] - 04/10/2024)

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

At approximately 1:45 p.m., the temperature in the white freezer, in the kitchen on the main level, measured 4 degrees Fahrenheit and at 2:39 p.m. the temperature measured 2 degrees.

At approximately 1:48 p.m., the temperature in the green refrigerator, in the kitchen on the main level, measured 45 degrees Fahrenheit and at 2:40 p.m. the temperature measured 46 degrees.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

Completed on 2/27/2024: The white freezer thermometer was replaced by the administrator with a new one and monitored temperature was turned down to assure proper temperature was being kept.
Completed on 2/27/2024: The green refrigerator thermometer was replaced by the administrator with a new one and the thermostat turned back to monitor and make sure it is maintaining a temperature below 40.
Both the white freezer and green refrigerator had new thermometers put in them to ensure equipment is working properly. Starting on 3/1/2024 direct care staff will weekly check thermometer and document on temperature charts and will notify the Administrator or Administrator Assistant immediately if temperatures are not accurate if not opening and rechecking in 1 hour.

Licensee's Proposed Overall Completion Date: *04/03/2024*

Implemented [redacted] - 04/10/2024)

103i - Outdated Food

6. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There was an opened and undated bag, containing fish patties, in the freezer chest on the lower level of the home.

Plan of Correction ***Accept (- 04/03/2024)***

The administrator disposed of the opened and undated fish on 2/23/2024. All refrigerators and freezers were immediately checked on 2/23/2024 by the administrator for any other opened and undated items. Starting on 2/24/2024 First shift med techs, the Administrator, or Administrator Assistant will check daily to make sure this is done.

Licensee's Proposed Overall Completion Date: *04/03/2024*

Implemented - 04/10/2024)

123b - Emergency Procedures Posted

7. Requirements

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

Description of Violation

The home's emergency procedures were not posted in a conspicuous and public place in the home. The emergency procedures were inside the Administration office.

Plan of Correction ***Accept - 04/03/2024)***

On 2/23/2024 the homes emergency procedures were copied and posted by the Administrator on to the bulletin board with the borough's emergency operation plan. Starting 3/1/2024 The Administrator or Administrator Assistant will check the board monthly for proper postings of policies.

Directed:

Within 7 days of receipt of the accepted plan of correction the administrator or designated staff person shall a

. 4/3/24

Proposed Overall Completion Date: 04/03/2024

Licensee's Proposed Overall Completion Date: *04/03/2024*

Implemented (- 04/10/2024)

133.2 - Exit Signs Direction

8. Requirements

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

Description of Violation

There were no exit signs over the exit door leading from the kitchen to the hallway, leading to emergency exit door #5.

133.2 - Exit Signs Direction (continued)

The door from the hallway leading, near exit door #5, into the kitchen had a "no exit" and "EXIT" sign on the door.

There were no exit signs on the door leading from the piano room into the rear hallway, near exit door #5.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

On 2/23/2024 the exit sign was placed by the administrator on the door leading from the kitchen to the hallway, leading to the emergency exit door #5. Starting on 3/1/2024 Monthly checks will be done to ensure signs are posted and secure by the Administrator, or Administrator Assistant.
On 2/23/2024 the "no exit" and "EXIT" sign was placed by the administrator on the door from the hallway leading, near exit door #5, into the kitchen. Starting on 3/1/2024 Monthly checks will be done to ensure signs are posted and secure by the Administrator, or Administrator Assistant.
On 2/23/2024 the exit sign was placed by the administrator on the door leading from the piano room into the rear hallway, near exit door #5. Starting on 3/1/2024 Monthly checks will be done to ensure signs are posted and secure by the Administrator, or Administrator Assistant.

Licensee's Proposed Overall Completion Date: *04/03/2024*

Implemented [redacted] - 04/10/2024)

141a - Medical Evaluation

9. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #1's medical evaluation, dated [redacted] is blank in the height section.

Resident #3's medical evaluation, dated [redacted], is blank in the height section.

Plan of Correction ***Accept ([redacted] - 04/03/2024)***

On 2/27/2024 Resident #1 medical evaluation that was blank in the height section had the height added and changed in Tabula by the administrator for future uses. The administrator also sent the updated medical evaluation to the Doctor to be resigned.
On 2/27/2024 Resident #3 medical evaluation that had a blank height section had height added by the administrator, height was then added to tabula and was sent to the doctor to be resigned.
All other medical evaluations checks were completed on 3/1/2024 by the administrator to make sure height was included on all of them. Moving forward the Administrator, or Administrator Assistant will double check the medical evaluation at admission to make sure all information is filled out.

Licensee's Proposed Overall Completion Date: *04/03/2024*

Implemented ([redacted] - 04/10/2024)

227g -Support Plan Signatures

10. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #1's support plan was not signed by the Assessor who completed the support plan.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

Resident #1's support plan that has not been signed by assessor was signed on [redacted].
On 2/23/2024 all RASPSs were checked by the administrator for all residents to make sure they were signed by the assessor.
Starting on 3/1/2024 the Administrator, or the Administrator Assistant will double check the RASPs at admission to ensure they are completed and signed by assessor.

Licensee's Proposed Overall Completion Date: *04/03/2024*

Implemented [redacted] - 04/10/2024)