pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **CA SENIOR MCCANDLESS OPERATOR LLC**
LEGAL ENTITY

To operate **RIDGECREST PERSONAL CARE & MEMORY CARE**
NAME OF FACILITY OR AGENCY

Located at **8870 DUNCAN AVENUE, PITTSBURGH, PA 15237**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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

The total number of persons which may be cared for at one time may not exceed **211** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 35**

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

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

and shall remain in effect from **January 13,** **2025** until **July 13,** **2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **452171**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JANUARY 13, 2025

[redacted], Regional Director of Operations
CA Senior McCandless Operator LLC
[redacted]

RE: Ridgecrest Personal Care & Memory Care
8870 Duncan Avenue
Pittsburgh, Pennsylvania 15237
License/COC #: 452171

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on July 18, 2024, August 5, 2024, August 6, 2024, August 14, 2024, and October 18, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), mistreatment or abuse of residents being cared for in the facility, failure to submit an acceptable plan to correct noncompliance items, and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby REVOKES your certificate of compliance (license number 452170) dated September 15, 2024 – September 15, 2025, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1); (5) and 55 Pa. Code §20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from January 13, 2025 to July 13, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
42(b)	II	134	$5	$670	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
[redacted]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *RIDGECREST PERSONAL CARE & MEMORY CARE* **License #:** *45217* **License Expiration:** *09/15/2024*

Address: *8870 DUNCAN AVENUE, PITTSBURGH, PA 15237*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *CA SENIOR MCCANDLESS OPERATOR LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *174* **Waking Staff:** *131*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date:** *07/18/2024*

Inspection Dates and Department Representative

07/18/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *211* **Residents Served:** *135*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Reflections* **Capacity:** *32* **Residents Served:** *25*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *134*

Diagnosed with Mental Illness: *6* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *39* **Have Physical Disability:** *0*

Inspections / Reviews

07/18/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/25/2024*

Inspections / Reviews *(continued)*

08/26/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/30/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/02/2024*

09/11/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/30/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/30/2024*

12/16/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *09/30/2024*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home 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

The following events occurred on Friday 7/5/24. Direct care staff person A who witnessed the events shared the incidents with staff person B later that evening. Staff person B reported the concerns to staff person C ( ) on Saturday, 7/6/24. The incidents were reported to staff person D, , on Tuesday, 7/9/24. The incidents were not reported to Protective Services at Allegheny County Area Agency on Aging until Tuesday 7/9/24.

On Friday, 7/5/24 between ., direct care staff person A was asked by direct care staff person E to assist to locate resident #1. When staff person E located resident #1 in another resident's bedroom, staff person A witnessed staff person E yelling at resident #1 stating, "What the are you doing in here? This isn't your room. Get the out of here. Come on get the up this isn't your room." Resident #1 was just waking up. Staff person E asked staff person A to help get resident #1 up. As staff person A was getting arm under the resident's arm and assisting staff person E, staff person E was saying "get the up." While the two staff persons were assistang resident #1 with ambulating, resident #1 stated, "You're hurting me." and was "full blown screaming" and trying to spit on staff person E. Resident #1 was saying, "I can't walk as fast. You're hurting me."

On Friday, 7/5/24 between direct care staff person A was asked by direct care staff person F to assist with getting resident #2 ready for bed. According to staff person A, when staff person F asked resident #2 if wants to get ready for bed, the resident responded that wasn't ready yet. Staff person F asked if could look under the back of shirt for a lump. Resident replied that doesn't have a lump on back. As soon as staff person F started lifting the resident's shirt, staff person F ripped the resident's shirt off. The resident stated "Don't. You're hurting me. You're hurting my head. I don't know why you did that. You hurt my shoulder. You hurt my neck." Then staff person F proceeded to remove the resident's pants as the resident was saying "I don't want my pants off. I don't want them off." Staff person F was reportedly yelling "I need to take your pants off. You need your pajamas on." Resident #2 was trying to hold pants on, lost balance and fell backwards onto chair saying, "I can't believe this. I shouldn't have to change my pants." Resident #2 was then left to finish getting pants on by as typically finishes dressing

Repeat Violation 1/30/24 et al., 11/29/23

Plan of Correction ***Accept (- 09/11/2024)***

On 7/5/24, a potential incident of abuse was witnessed by Staff Person A, who unfortunately did not report it to a direct manager or supervisor. The incident was only reported to Staff Person B, and was not made aware until 7/9/24. Staff Persons A and B were interviewed, and their statements were documented. On 7/9/24, the Administrator took immediate action, suspending Staff Person A and B and terminating them on

On 7/9/24, swift and decisive actions were taken to address the situation. The residents were promptly checked for any marks or discolorations, and the Healthcare Director and Memory Care Director confirmed no signs of abuse. The Memory Care Director interviewed the residents to ensure their safety, and the Administrator promptly

15a - Resident Abuse Report (continued)

informed the respective families and PCPs. Current associates were re-educated on 7/9 & 7/12/24 on the steps set by Adult Protective Services abuse reporting protocol and Regulation 2600.15a, Resident Abuse Report. This training will continue with new hires to ensure the critical nature of the timeliness of reporting so as not to incur other occurrences from those associates in question until the fact-finding is completed and addressed.

Beginning 7/9/24, potential subsequent occurrences will be reported via phone at the time they occur in the timeline set forth by Adult Protective Services and the Department. The written report shall follow in 24 hours with the documentation/notification to the respective agency. These reports, if any, will be kept in the resident record.

New associates will be educated on this regulation guideline and its importance during their onboarding training, which will occur within the first eight hours of employment and subsequent annual training. This education will be kept in the associate file, demonstrating our commitment to ensuring all staff know and understand their responsibilities in preventing abuse.

Beginning 7/9/24, the Healthcare Director/Assistant Healthcare Director/designee will monitor incident reports daily. Those incident reports will be discussed in the monthly QMPI meeting, which is scheduled next for 8/28/24. Documentation will be kept in the Administrator's office.

The current staff include direct care staff (DCS), culinary, housekeeping, maintenance, consigner, and/or administrative managers. Current staff were educated on the regulation 2600.15a and Ridgecrest Resident Abuse Report policy and procedure on abuse and the reporting procedures by the Administrator on August 27th 2024. Associates that were not in attendance will complete this training on the regulation of 2600.15a and Ridgecrest Resident Abuse Report policy and procedure on abuse and the reporting procedures by the Health Care Director/Administrator/designee by September 13th 2024. The documentation of this education will be kept in accordance with Regulation 2600.65(i).

Licensee's Proposed Overall Completion Date: *09/30/2024*

Implemented ([redacted] - 12/16/2024)

16c - Written Incident Report

2. Requirements

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

Description of Violation

The following events occurred on Friday 7/5/24. Direct care staff person A who witnessed the events shared the incidents with staff person B later that evening. Staff person B reported the concerns to staff person C [redacted] on Saturday, 7/6/24. The incidents were reported to staff person D, [redacted], on Tuesday, 7/9/24. The incidents were not reported to the Department until Tuesday 7/9/24.

On Friday, 7/5/24 between [redacted] direct care staff person A was asked by direct care staff person E

16c - Written Incident Report (continued)

to assist [redacted] to locate resident #1. When staff person E located resident #1 in another resident's bedroom, staff person A witnessed staff person E yelling at resident #1 stating, "What the [redacted] are you doing in here? This isn't your room. Get the [redacted] out of here. Come on get the [redacted] up this isn't your room." Resident #1 was just waking up. Staff person E asked staff person A to help [redacted] get resident #1 up. As staff person A was getting [redacted] arm under the resident's arm and assisting staff person E, staff person E was saying "get the [redacted] up." While the two staff persons were assistang resident #1 with ambulating, resident #1 stated, "You're hurting me." and was "full blown screaming" and trying to spit on staff person E. Resident #1 was saying, "I can't walk as fast. You're hurting me."

On Friday, 7/5/24 between [redacted] direct care staff person A was asked by direct care staff person F to assist with getting resident #2 ready for bed. According to staff person A, when staff person F asked resident #2 if [redacted] wants to get ready for bed, the resident responded that [redacted] wasn't ready yet. Staff person F asked if [redacted] could look under the back of [redacted] shirt for a lump. Resident replied that [redacted] doesn't have a lump on [redacted] back. As soon as staff person F started lifting the resident's shirt, staff person F ripped the resident's shirt off. The resident stated "Don't. You're hurting me. You're hurting my head. I don't know why you did that. You hurt my shoulder. You hurt my neck." Then staff person F proceeded to remove the resident's pants as the resident was saying "I don't want my pants off. I don't want them off." Staff person F was reportedly yelling "I need to take your pants off. You need your pajamas on." Resident #2 was trying to hold [redacted] pants on, lost [redacted] balance and fell backwards onto [redacted] chair saying, "I can't believe this. I shouldn't have to change my pants." Resident #2 was then left to finish getting [redacted] pants on by [redacted] as [redacted] typically finishes dressing [redacted]

Repeat Violation 1/30/24 et al., 11/29/23

Plan of Correction ***Accept ([redacted] - 09/11/2024)***

On 7/5/24, a potential incident of abuse was witnessed by Staff Person A, who unfortunately did not report it to a direct manager or supervisor. The incident was only reported to Staff Person B, and the Administrator was not made aware until 7/9/24. Staff Persons A and B were interviewed, and their statements were documented. On 7/9/24, the Administrator took immediate action, suspending Staff Person A and Staff Person B and terminating them on [redacted]

On 7/9/24, immediate actions were taken to address the situation. The residents were promptly checked for any marks or discolorations, and the Healthcare Director and Memory Care Director confirmed no signs of abuse. The Memory Care Director interviewed the residents to ensure their safety, and the Administrator promptly informed the respective families and PCPs. Current associates were re-educated on 7/9 & 7/12/24 on the steps set by Adult Protective Services abuse reporting protocol and Regulation 2600.16c, Written Incident Report. This training will continue with new hires to ensure the critical nature of the timeliness of reporting so as not to incur other occurrences from those associates in question until the fact-finding is completed and addressed.

Beginning 7/9/24, potential subsequent occurrences will be reported via phone at the time they occur in the timeline set forth by Adult Protective Services and the Department. The written report shall follow in 24 hours with the documentation/notification to the respective agency. These reports, if any, will be kept in the resident record.

New associates will be educated on this regulation guideline and its importance during their onboarding training, which will occur within the first eight hours of employment and subsequent annual training. This education will be kept in the associate file.

Beginning 7/9/24, the Healthcare Director/Assistant Healthcare Director/designee will monitor incident reports

16c - Written Incident Report (continued)

daily. Those incident reports will be discussed in the monthly QMPI meeting, which is scheduled next for 8/28/24. Documentation will be kept in the Administrator's office.

The 2600.16c was trained by the administrator to current staff including Direct Care Staff, Culinary, housekeeping, maintenance, concierge and department managers on July 9th and July 12 2024. Documentation of this education will be kept in accordance of 2600.65(i).

Additional training on Ridgecrest's Policy and procedures for Resident Abuse neglect and exploitation was presented by the Administrator on August 27th and will be ongoing, to current Direct Care Staff, Culinary, housekeeping, maintenance, concierge and department managers. The remaining staff training on 2600.16c and Ridgecrest's policy and procedures will be completed by the HCD/Administrator/designee by September 13th 2024 and ongoing. This documentation of this education will be kept in accordance of 2600. 65(i).

New Hire staff will also be educated on the 2600.16c and the Ridgecrest policy and procedures in Resident abuse, neglect and exploitation. This documentation of this education will be kept in accordance of 2600. 65(i).

Licensee's Proposed Overall Completion Date: *09/30/2024*

Implemented (- 12/16/2024)

42b - Abuse

3. Requirements

2600.

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 Friday, 7/5/24 between [redacted] direct care staff person A was asked by direct care staff person E to assist [redacted] to locate resident #1. When staff person E located resident #1 in another resident's bedroom, staff person A witnessed staff person E yelling at resident #1 stating, "What the [redacted] are you doing in here? This isn't your room. Get the [redacted] out of here. Come on get the [redacted] up this isn't your room." Resident #1 was just waking up. Staff person E asked staff person A to help [redacted] get resident #1 up. As staff person A was getting [redacted] arm under the resident's arm and assisting staff person E, staff person E was saying "get the [redacted] up." While the two staff persons were assisting resident #1 with ambulating, resident #1 stated, "You're hurting me." and was "full blown screaming" and trying to spit on staff person E. Resident #1 was saying, "I can't walk as fast. You're hurting me."

On Friday, 7/5/24 between [redacted] direct care staff person A was asked by direct care staff person F to assist with getting resident #2 ready for bed. According to staff person A, when staff person F asked resident #2 if [redacted] wants to get ready for bed, the resident responded that [redacted] wasn't ready yet. Staff person F asked if [redacted] could look under the back of [redacted] shirt for a lump. Resident replied that [redacted] doesn't have a lump on [redacted] back. As soon as staff person F started lifting the resident's shirt, staff person F ripped the resident's shirt off. The resident stated "Don't. You're hurting me. You're hurting my head. I don't know why you did that. You hurt my shoulder. You hurt my neck." Then staff person F proceeded to remove the resident's pants as the resident was saying "I don't want my pants off. I don't want them off." Staff person F was reportedly yelling "I need to take your pants off. You need your pajamas on." Resident #2 was trying to hold [redacted] pants on, lost [redacted] balance and fell backwards onto [redacted] chair saying, "I can't believe this. I shouldn't have to change my pants." Resident #2 was then left to finish getting [redacted] pants on by [redacted] as [redacted] typically finishes dressing [redacted]

42b - Abuse (continued)

Repeat Violation 1/30/24 et al.

Plan of Correction ***Accept (- 09/11/2024)***

On 7/5/24, it was identified that Staff Person E and Staff Person F were witnessed being rough with care and verbally vulgar with memory care residents during evening care. The community failed to protect the residents from abuse and neglect.

Staff Persons E and F were interviewed, and their statements were documented. On 7/9/24, the Administrator took immediate action, suspending Staff Person E and F and terminating them on .

On 7/9/24, swift and decisive actions were taken to address the situation. The residents were promptly checked for any marks or discolorations, and the Healthcare Director and Memory Care Director confirmed no signs of abuse. The Memory Care Director interviewed the residents to ensure their safety, and the Administrator promptly informed the respective families and PCPs. Current associates were re-educated on 7/9 & 7/12/24 on the steps set by Adult Protective Services abuse reporting protocol and Regulation 2600.42b, Abuse. This training will continue with new hires to ensure the critical nature of the timeliness of reporting so as not to incur other occurrences from those associates in question until the fact-finding is completed and addressed.

Beginning 8/20/24, the Memory Care Director/AHCD will interview five residents in the Memory Care neighborhood privately each month for three months to ensure they feel safe from neglect or abuse. Those interviews will be discussed in the monthly QMPI meeting, which is scheduled next for 8/28/24. Documentation will be kept in the Administrator's office.

Each shift will be monitored by the HCD/AHCD/Nurse/Medication Technician during their working shifts for any suspicion of abuse neglect and or exploitation and report any occurrences immediately to the administrator or immediate manager/designee.
On 9/27/24 current associates were re-educated on 2600.42 resident rights and 2600.42b by the administrator and associates that did not attend shall received by September 13th 2024 and will ongoing by the HCD/AHCD/Administrator/designee on 2600. 42 and 2600.42b The Legend policy and procedure of resident abuse, neglect and exploitation was also trained on August 28th 2024 and ongoing by the Administrator/designee. This documentation of this education will be kept in accordance of 2600. 65(i).

Current Direct Care Staff and management staff and administrator/Assistant Administrator will receive out-sourced training from Older Adult Protective Services on abuse reporting and prevention by September 30th 2024. Documentation of this education will be kept in accordance with regulation 2600.65(i).
Additional training for Direct Care staff was provided additional re-education on providing care services to Residents with dementia and behaviors. This training was acquired through Alzheimer's Association and Medical Mutual on de-escalation technics and sensitivity training. The re-education was provided by the HCD and administrator on July 30th. 2024 and will be ongoing with new hires. This documentation of this education will be kept in accordance of 2600. 65(i).

As stated in the submitted Plan of Correction the staff person E and F were terminated on

42b - Abuse *(continued)*

Licensee's Proposed Overall Completion Date: *09/30/2024*

Not Implemented (- 12/16/2024)

225c - Additional Assessment

4. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #2 was admitted to the home on . The resident's most recent assessment was completed . However, the resident's previous assessment was completed on .

Repeat violation 3/28/24

Plan of Correction ***Accept (- 09/11/2024)***

The home failed to complete an annual assessment for Resident #2 in . Resident #2 was admitted to the home on . The most recent assessment was completed on but the previous assessment was completed on .

Respectfully, Legend Senior Living acquired the management of Ridgecrest Personal Care and Memory Care on 12/15/23. The audit process of the existing files for compliance with Regulation 2600.225c, Additional Assessments, began. It was determined via that audit that numerous assessments were incomplete, so the recruitment of an Wellness Nurse started and was hired on .

On 1/31/24, the Administrator trained the Wellness Nurse on Regulation 2600.225c. At the time, many resident assessments were identified as late, incomplete or not in the chart.

Since 2/1/24, current residents admitted are fully compliant with Regulation 2600.225c and any additional Assessments required have been completed. The Healthcare Director/Assistant Healthcare Director/designee has initiated an ongoing audit of the company's shared drive ensuring any changes with move-in and significant assessment changes are promptly recorded, thereby keeping the process current and comprehensive.

Adherence to 2600.225c, Additional Assessments, is not just a requirement but a commitment to the safety and well-being of our residents. We will rigorously monitor this during our regularly scheduled Quality Assurance meetings, with the next meeting on 8/28/24, ensuring that all ongoing audits are reviewed and necessary actions are taken. Comprehensive documentation of these meetings will be maintained for reference, demonstrating our proactive approach to compliance.

Resident #2 had an annual corrected and completed update made. The annual RASP was completed late due to the acquisition and change in management of the community by Legend Senior Living. When the audit was completed in January 2024 and appropriate staff were hired and trained. Resident #2 RASP was completed on by the Memory Care Director. It is now documented on the RAPS that "After the new Management Audit was completed this RASP has been corrected and completed by Memory Care Director on ."

225c - Additional Assessment (continued)

Other corrected and completed RASP will be documented as such with the signature of the position correcting the RAPS at the time of completion. This will be completed by September 30 2024 by the Healthcare Director/Assistant Healthcare Director/Memory care Director.
The initial Audit was completed in Jan. 2024. The process of this ongoing audit is maintained since February 2024 and documented on the Ridgecrest shared drive and updated by the Heath care Director/Assistant Healthcare Director/designee when annual RASP's are completed, when a new resident moves in, and or a significant change occurs for the residents. This process is ongoing. This audit will be reviewed in the QMPI meeting each month. The next QMPI is scheduled for September 24th 2024 and will ongoing time 3 months.
Current residents are up to date and in compliance.

Licensee's Proposed Overall Completion Date: *09/30/2024*

Not Implemented (- 12/16/2024)

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

Facility Information

Name: *RIDGECREST PERSONAL CARE & MEMORY CARE* **License #:** *45217* **License Expiration:** *09/15/2024*

Address: *8870 DUNCAN AVENUE, PITTSBURGH, PA 15237*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *CA SENIOR MCCANDLESS OPERATOR LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date:** *06/19/2020* **Issued By:** *Township of McCandless*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *181* **Waking Staff:** *136*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date:** *08/14/2024*

Inspection Dates and Department Representative

08/05/2024 - On-Site: [redacted]

08/06/2024 - On-Site: [redacted]

08/14/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *211* **Residents Served:** *141*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *SDCU/1ST FLOOR* **Capacity:** *35* **Residents Served:** *24*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *140*

Diagnosed with Mental Illness: *5*

Diagnosed with Intellectual Disability: *1*

Have Mobility Need: *40*

Have Physical Disability: *0*

Inspections / Reviews

08/05/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/19/2024*

09/26/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/17/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/02/2024*

10/10/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/17/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/17/2024*

12/16/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *10/17/2024*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

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

On 8/5/2024, the following licensing inspection summaries issued by the Department, on the listed dates, were not posted in a conspicuous and public place in the home:

- *4/15/2024*
- *3/28/2024*
- *1/30/2024*
- *11/29/2023*
- *10/4/2022*

Plan of Correction ***Accept (- 09/23/2024)***

The current LIS was posted in a conspicuous area in the front of the community. The additional LIS for 2024 were found missing.

The additional LIS's were immediately added on the board on this inspection date of 8-6-2024 by Maintenance Director and Acting Residence Director.

The Regional Director of Operations or designee will re-educate the Residence Director, Assistant Residence Director and Business Office Manager on the requirement to post a copy of the current licensing inspection summary (LIS) by 9/17/2024. Documentation of the training shall be kept.

Beginning 9/17/2024, The Residence Director or Designee shall audit the public posting of the LIS(s) monthly, for three months, to ensure compliance with Regulation 3c. Documentation of the audit shall be kept.

Effective 8/6/2024, the Residence Director/Designee will immediately post the copy of any LIS received on the actual date in the consistent conspicuous area.

Licensee's Proposed Overall Completion Date: *09/30/2024*

Implemented (- 12/16/2024)

23a - Activities of Daily Living Assistance

2. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

According to the assessment of resident #1, the resident is diagnosed with dementia, back pain, and weakness. The resident requires physical assistance for showering and dressing and requires staff assistance to escort or push wheelchair because of a physical limitation. On , at approximately was found on the floor by direct care staff person A after an unwitnessed fall. Staff person B. , assessed resident #1.

23a - Activities of Daily Living Assistance (continued)

The resident did not exhibit any outward injuries, complain of any pain and vital signs were within normal limits. Staff assisted the resident back into bed. Neither direct care staff persons A or B documented resident #1's fall during that shift, nor did they notify oncoming staff that the resident had fallen.

However, the next morning, [redacted], at approximately [redacted] resident #1 complained to direct care staff person C of right side pain, including legs and arm. Staff person C reported the resident tried to move [redacted] leg and [redacted] heard a "popping" sound. Staff person D, [redacted] was notified but did not reassess the resident, and administered Tylenol. The Tylenol was not effective., and [redacted] staff person D sent the resident to the hospital. The ambulance arrived at the facility at [redacted] and at the hospital at [redacted] The resident was diagnosed with right arm and right hip fracture.

The staff on duty during the morning of [redacted] were were not aware that the resident had fallen the previous evening and therefore did not reassess the resident, causing a delay in the resident's medical treatment. Also, EMS and hospital personnel were not informed of the unwitnessed fall.

Plan of Correction ***Accept ([redacted] - 09/24/2024)***

Resident #1 is currently out of the Residence. The Health Care Director, or designee, shall reevaluate resident upon return and update required assessments.

By 9/30/2024, the Health Care Director shall educate direct care staff on the Community's policies and procedures regarding their responsibility to provide assistance with ADLs as indicated in each residents Assessment and Support Plan and how to find this information. This training shall also include instruction on response, notification, reporting and documentation of incidents such as unwitnessed falls.

Beginning 9/19/2024 and ongoing for 30 days, the Health Care Director, or designee, shall review the incident report and provide guidance and/or interventions to ensure ongoing compliance with regulation 23a. Communication logs shall be kept for 30 days.

Beginning 09/24/24, during the QMPI meeting, the Residence Director or designee shall review resident care related topics to provide continued quality improvement guidance and intervention to all departments.

Licensee's Proposed Overall Completion Date: *09/30/2024*

Not Implemented ([redacted] - 12/16/2024)

42b - Abuse

3. Requirements

2600.
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] at approximately [redacted] staff person E, heard staff person F yelling and swearing at resident #2 while staff person F was assisting the resident in the bathroom. Staff person B said to the resident "Sit [redacted] still!" and "Stop [redacted] fighting me!" The resident said twice "Stop you are hurting me!" Staff person F continued yelling at the resident and resident #2 began apologizing to direct care staff F.

42b - Abuse (continued)

Repeat Violation 1/30/2024 et al

Plan of Correction ***Accept (- 10/10/2024)***

Upon notice of the allegation of abuse on [redacted], the staff members B and F were placed on administrative leave pending investigation and subsequently terminated from employment on [redacted]

Upon notice of the allegation of abuse on [redacted], the Health Care director and other direct care staff responded to the resident to provide comfort and investigate the allegations. Resident found to show no signs or symptoms of distress. Resident does/does not remember the event.

By 9/30/24, the Residence Director, or designee, shall have conversations with at least 10 residents to evaluate any potential mistreatment that has not been reported. Verbalizations of mistreatment shall be reported immediately per regulatory requirements.

The Residence Director or designee shall re-educate current staff on the definition of abuse and neglect, prevention, and how it relates to residents' rights, duties, and responsibilities as caregivers by 9/25/24. Documentation shall be kept.

Beginning 9/16/24 and as part of our ongoing commitment to staff development and resident safety, staff shall receive training on preventing abuse and neglect upon hire, annually, or as needed. This training will be provided through Relias and/or face-to-face sessions led by the Administrator, Business Office Manager, or Healthcare Director. Documentation shall be kept.

Beginning 9/19/24, the Residence Director or Health Care Director, or designee, shall review incident reports at least three times per week to review for allegations of abuse and neglect that were not reported per requirements.

Beginning 9/24/24 during the QMPI meeting, the Residence Director or designee shall review all allegations of abuse and neglect and provide continued quality improvement guidance and intervention to all departments in accordance with the Older Adult Protective Services Act.

The administrator will implement procedures that ensure compliance with §2600.42(b). The procedures will include, at a minimum, monthly the Residence Director and/or designee will interview at least 4 residents regarding care and treatment, including assistance with incontinence care, bathing, repositioning and bathing. The administrator or designee will increase supervision of staff during care with assistive devices to ensure that staff are promptly and proficiently assisting residents with mobility needs in a manner that's compliant with §2600.42(b). Documentation will be kept.

Licensee's Proposed Overall Completion Date: *10/11/2024*

Not Implemented (- 12/16/2024)

42s - Privacy

4. Requirements

42s - Privacy *(continued)*

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

The home has video cameras to monitor entrances and common areas of the home; however, on 8/5/2024 at 11:10 am, there were no signs posted to notify residents, staff and visitors that video monitoring in progress.

Plan of Correction ***Accept (- 09/26/2024)***

It was identified on 8/6/2024 the signs being posted in the areas being monitored were not present in entrances and exits and the interior corridors leading to entrances and exits. This was immediately framed and posted at the entrance of the community and entrance to the elevators by the Maintenance Director on 8/6/2024. This action assures the resident rights to privacy while living in the community.

The Residence Director or designee shall educate the Maintenance Director on posting signs in any area of the community with a camera by 9/19/2024. Documentation shall be kept.

Beginning 9/19/2024 and then once a month, for 3 months, The Maintenance Director or designee shall check that there are signs posted to inform residents, staff and visitors that video cameras are in place. Documentation of the checks and any additional posting added shall be kept.

During the QMPI meeting the Residence Director or designee hall review the monthly audit of the signage to ensure it is being maintained in the necessary areas to assure it is consistent with the regulation of residents right to privacy. This will begin 9/24/24.

Licensee's Proposed Overall Completion Date: *09/30/2024*

Implemented (- 12/16/2024)

63a - First Aid/CPR Training

5. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

From 11:00 pm on 8/4/2024 to 7:00 am on 8/5/2024 there were only 2 staff persons present in the home who were trained in first aid and certified in obstructed airway techniques and CPR. On this date, there were 141 residents in the home, therefore 3 staff with this training and certification were required to be present.

From 11:00 pm on 7/31/2024 to 7:00 am on 8/1/2024 there were only 2 staff persons present in the home who were trained in first aid and certified in obstructed airway techniques and CPR. On this date, there were 142 residents in the home, requiring 3 staff with training and certification to be present.

From 11:00 pm on 7/30/2024 to 7:00 am on 7/31/2024 there were only 2 staff persons present in the home who were trained in first aid and certified in obstructed airway techniques and CPR. On this date,, there were 139 residents in the home, requiring 3 staff with training and certification to be present.

63a - First Aid/CPR Training (continued)

Plan of Correction ***Accept ([redacted] - 09/26/2024)***

It was identified on 8-7-2024 there was a lack of 1 additional CPR/first aid trained associate on the schedule for July 30, 31, and August 4th on the 11pm-7am shift.
On 8/7/2024, the Scheduler reviewed current staff training records for current CPR and First Aid Training and created a list of who needs CPR and First Aid Training and those who's training is about to expire.

On 8/7/2024, the Direct Care Staff Scheduler compared the list to the current schedule and made adjustments to the schedule to ensure required CPR and First Aid trained staffing levels for all shifts.

Beginning 9/19/24 the Healthcare Director, or designee, shall review the upcoming weekly schedule and make adjustments with the Direct Care Staff Scheduler to ensure required CPR and First Aid trained staffing levels for all shifts.

The Health Care Director has scheduled a CPR/First aid class for August 29th 230pm and September 11th 2:30 pm for staff who need training. There is an additional class scheduled for October 22nd at 2pm. The Health Care Director shall schedule routine CPR/First aid training classes, at least bi-annually, to make sure that CPR/First Aid trained staff are available to meet requirement 2600.63a.

By 9/19/2024, The Residence Director or Designee shall educate the Health Care Director, Scheduler and Business Office Manager on tracking CPR and First Aid training and reviewing current training when preparing the schedule to ensure compliance with 63a. Documentation of education shall be kept.

During the next QMPI meeting on 9/24/24, the Residence Director or designee shall review the CPR and First Aid training list at the monthly QMPI to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *09/30/2024*

Implemented ([redacted] - 12/16/2024)

65i - Training Record

6. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home has no record of staff person B's annual training for 2023.

Plan of Correction ***Accept ([redacted] - 09/26/2024)***

It was identified on 8/7/2024, during inspection that a closed associate file could not verify annual training requirements for 2023. Legend Senior Living assumed management of Ridgecrest on December 15th, 2023.

By 9/30/24, the Business Office Manager shall audit staff files to ensure staff training is being completed. Any staff who are not on track will be assigned time to complete the required training to ensure compliance with regulation 65i.

65i - Training Record (continued)

By 9/17/2024, the Residence Director or designee shall train the Business Office Manager on training requirements including but not limited to State required training, documentation, record keeping and monitoring for compliance throughout the training year. Documentation shall be kept.

By next QMPI meeting on 9/24/24 the Residence Director, or designee, shall review staff that have not completed training per the training plan and shall work with the QMPI committee on a plan to ensure completion per regulation 65i.

Licensee's Proposed Overall Completion Date: *09/30/2024*

Implemented ([redacted] - 12/16/2024)

88a - Surfaces

7. 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 fire doors in the following locations do not close completely:

* *1st floor near rooms #101 and #102*
* *3rd floor near room #321*

Plan of Correction ***Accept ([redacted] - 09/26/2024)***

It was identified during this inspection on 8/6/2024 the fire doors located near room 102 and 321 did not latch completely when closed. On 8/6/2024 The Maintenance Director and Assistant Maintenance Director immediately did the manual adjustments to both doors on 8-6-2024 and they validated that they closed completely for fire safety to both areas of the 1st and 3rd floor.

On 8/7/2024, the Maintenance Director, or designee, checked the remaining fire doors to ensure they closed correctly. Adjustments were made during the checks and validation of closure. Beginning 9/17/24, Maintenance Director, or designee, shall check fire doors during monthly fire drills.

By 9/17/2024, The Residence Director, or designee, shall re-educate the Maintenance staff on the importance of checking the operation of fire doors, at least monthly, to ensure safe operation. Documentation shall be kept.

Beginning at the next QMPI meeting on 9/24/24 the QMPI committee shall review the results of the audits and make additional recommendations based on the audit results. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *09/30/2024*

Implemented ([redacted] - 12/16/2024)

107c - Food/Water 3 Day Supply

8. Requirements

107c - Food/Water 3 Day Supply *(continued)*

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 8/5/2024, the home served 141 residents, requiring 423 gallons of emergency drinking water. The home stores 135 gallons on-site.

The home has a contract with a local bottled water supplier, however, the contract does not include the following:

* *A guarantee that the water will be delivered immediately upon request, 24 hours per day.*
* *A guarantee that the water will be delivered as a priority even in the event of a regional general emergency.*

Plan of Correction ***Accept ([redacted] - 09/26/2024)***

The home currently has enough water for each resident for 24 hours; however, it was identified the emergency water contract did not have a specific delivery timeline if an emergent need for additional water occurs.

The home has secured an order to have water delivered to store on site to assure that there is enough water on site for each resident to meet 2600.107c by 9/30/24.
By 9/17/2024, The Residence Director, or designee, shall re-educate the Maintenance Director and Chef on assuring the home maintains the required amount of emergency water on site for the number of residents served. Documentation shall be kept.

Beginning on 10/1/24, the Maintenance Director, or designee, will check the water supply to assure it meets the needs based on the number of residents served. Audits will be done monthly.

Beginning at the next QMPI meeting on 9/24/24 the QMPI committee shall review the results of the audits and make additional recommendations based on the audit results. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *09/30/2024*

Implemented ([redacted] - 12/16/2024)

123b - Emergency Procedures Posted

9. 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 emergency preparedness plan for the municipality was not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept ([redacted] - 09/26/2024)***

The Maintenance Director posted the emergency preparedness plan for the municipality in a public and conspicuous place on 8/7/2024.

The Resident Director, or designee, shall re-educate the Maintenance Director by 9/17/24 on the requirement to always post the homes and municipality's emergency preparedness plans in a public and conspicuous place.

123b - Emergency Procedures Posted (continued)

Beginning 9/18/24, Maintenance Director, or designee, shall check the area where the emergency plans are posted once a week for 4 weeks to ensure ongoing compliance. Documentation shall be kept

These checks shall be reviewed beginning at the next QMPI meeting on 9/24/24.

Licensee's Proposed Overall Completion Date: *09/30/2024*

Implemented ([redacted] - 12/16/2024)

131c - Kitchen Fire Extinguisher

10. Requirements

2600.
131.c. A fire extinguisher with a minimum 2A-10BC rating shall be located in each kitchen. The kitchen extinguisher must meet the requirements for one floor as required in subsection (a).

Description of Violation

There was no fire extinguisher near the stove in the kitchen in the first floor family suite.

Plan of Correction ***Accept ([redacted] - 09/26/2024)***

On 8/7/24, the maintenance director purchased and installed the appropriate fire extinguisher in the kitchen area and it is posted with signage for its location. In addition, on 8/7/2024, the Maintenance Director, or designee, checked all other kitchen areas to ensure they have a 2A-10BC fire extinguisher.

By 9/17/24, the Residence Director will re-educate the Maintenance Director on ensuring any kitchen area that can prepare and store food in a capacity that would designate it as "full service" shall have a 2A-10BC fire extinguisher. Maintenance Director, or designee, shall audit fire extinguisher locations at least monthly for compliance.

Beginning 9/24/24, the monthly inspections shall be presented and discussed at the monthly QMPI for continued compliance with regulation 131c. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *09/30/2024*

Implemented ([redacted] - 12/16/2024)

132b - Safety Inspection/Fire Drill

11. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home did not have a fire drill conducted by a fire safety expert in the past year.

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

A fire safety expert has been retained to conduct this important educational drill at an unannounced time. This will be conducted by a third-party fire safety inspector by the end of September 2024.

132b - Safety Inspection/Fire Drill (continued)

The Residence Director or designee shall re-educate the Maintenance Director on the requirement for annual supervised fire drills and fire safety inspection by 9/18/24.

The Maintenance Director shall request a task be added to the TELS electronic maintenance management system by 9/20/2024 to be alerted prior to the due date to ensure timely scheduling of the annual supervised drill and fire safety inspection.

Beginning on at the next QMPI meeting on 9/24/24, the committee shall review the fire drill log to ensure compliance with regulation 132b. Documentation shall be kept. ***Fire Drill/Inspection was completed on 9/24/24 by a third party provider***

Licensee's Proposed Overall Completion Date: *10/02/2024*

Implemented ([redacted] - 12/16/2024)

144c1 - Smoking Area Guidelines

12. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

On 8/5/2024 at approximately 10:15, there was a flammable cushion on a bench in the staff smoking area.

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

It was identified during the inspection on 8/6/2024 that the smoking area for associates contained a cushion on the metal chair was not marked "flame retardant". The cushion was immediately removed and disposed of on 8/6/2024.

The Residence Director or designee will in-service the Maintenance Director of the fire safe concerns of the cushion identified being out of compliance for the safety of others by 9/18/24.

Beginning 9/19/24, the Maintenance director, or designee, shall check the smoking area at least three times weekly for 30 days to ensure there are no flammable items such as cushions in the smoking area. Record of the checks shall be kept. After thirty days, audits will continue to weekly and reported to monthly QMPI Committee for review.

Beginning on at the next QMPI meeting on 9/24/24, the committee shall review the checks for continued compliance with regulation 144c1

Licensee's Proposed Overall Completion Date: *10/04/2024*

Implemented ([redacted] - 12/16/2024)

184a - Resident's Meds Labeled

13. 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

There was no pharmacy label on resident #4's prescription Brimonidine Tartrate-Timolol 0.2% - 0.5% eye drops, instill 1 drop in each eye every day. The box was only marked with the resident's name and the date that the eye drops were opened.

Plan of Correction ***Accept ([redacted] - 09/26/2024)***

This medication was resolved by placing the change of direction See MAR For Instructions. The resident was receiving the order as directed by the physician.

By 9/30/24, the healthcare director, or designee, reeducated medication passers on the regulation 184a, that all prescription medications are to have a pharmacy label.

On 9/17/24, the health care director, or designee completed an audit of the medication cart to make sure that medications requiring a prescription have pharmacy labeling.

Beginning 9/9/24 the healthcare director, or designee, shall complete a weekly medication cart audit for 2 weeks and then monthly thereafter.

Beginning at the next QMPI meeting on 2/24/24, the committee shall review continued compliance with regulation 184a.

Licensee's Proposed Overall Completion Date: *09/30/2024*

Implemented ([redacted] - 12/16/2024)

187d - Follow Prescriber's Orders

14. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #5 is prescribed Levothyroxine Sodium 88 mcg, take 1 tablet by mouth every morning. However, the medication was not administered to the resident on 8/3/2024 and 8/4/2024 because the medication was not available in the home.

Resident #4 is prescribed Sertraline 50 mg, take 1 tablet by mouth every day. However, the medication was not administered to the resident on 8/2/2024 and 8/3/2024 because the medication was not available in the home.

Resident #3 is prescribed Melatonin 5 mg, take 1 tablet by mouth at bedtime. According to the August medication administration record (MAR) the Melatonin was not administered to the resident from 8/1/2024 through 8/5/2024

187d - Follow Prescriber's Orders (continued)

because the medication was not available in the home.

Repeat Violation 1/30/2024 et al

Plan of Correction ***Accept ([redacted] - 09/26/2024)***

On 9/17/24; Resident #5, resident's representative and resident's physician notified of missed medications. DHS reportable sent on 9/17/24.
On 9/17/24; Resident #4, resident's representative and resident's physician notified of missed medication. DHS reportable sent on 9/17/24
On 9/17/24; Resident #3, resident's representative and resident's physician notified of missed medication. DHS reportable sent on 9/17/24.

By 9/30/24, the Health Care Director, or designee educated staff who administer medications on regulation 187d specifying the need to have medications as prescribed and the need to refill prior to completion of current supply.
By 9/30/24, the Healthcare Director or designee will audit current resident medications for compliance with 187d.

Beginning 9/23/24, the Healthcare director, or designee, shall complete a weekly medication cart audit for 2 weeks and then monthly thereafter.

Beginning at the next QMPI meeting on 9/24/24 the committee shall review audits for continued compliance with regulation 187d.

Licensee's Proposed Overall Completion Date: *09/30/2024*

Implemented ([redacted] - 12/16/2024)

224a - Preadmission Screen Form

15. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #6 was admitted to the home on [redacted]; however, the resident's preadmission screening was completed on [redacted].

Plan of Correction ***Accept ([redacted] - 09/26/2024)***

On 8/7/24, health care director, or designee, reviewed prescreen and noted that the prescreen was conducted late.

The Residence Director or designee shall re-educate the Health Care Director, Assistant Health Care Director and Memory Care Director on regulation 224 by 9/19/24, specifically ensuring all prospective residents have a preadmission screening completed on the departments form within 30 days prior to move in. Documentation of this training shall be kept.

224a - Preadmission Screen Form (continued)

The Health Care Director, or designee will complete an audit by 9/30/24 of current residents to assure compliance with 224a. Beginning 9/30/24, the Residence Director, or designee will audit all new move in charts for adherence to 224a.

Beginning at the next QMPI meeting on 9/24/24, shall review the results of the audits and make additional recommendations based on the audit results. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *09/30/2024*

Implemented ([redacted] - 12/16/2024)

227g -Support Plan Signatures

16. 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 #4's support plan, dated [redacted] was not signed by the resident, resident representative, or assessor.

Repeat Violation 1/30/2024 et al. and 11/29/2023

Plan of Correction ***Accept ([redacted] - 09/26/2024)***

On 8/13/24, Resident #4 RASP dated [redacted] reviewed with resident and resident representative; signed by resident, representative and staff member reviewing information and noted lateness of signatures. Resident #4 has since had a new RASP signed 7/3/24.

The Residence Director or designee shall re-educate the Health Care Director, Assistant Health Care Director and Memory Care Director on regulation 227 by 9/19/24, specifically ensuring RASPs are signed accordingly. Documentation of this training shall be kept.

The Health Care Director, or designee will complete an audit by 9/30/24 of current residents to assure compliance with 227g.

Beginning at the next QMPI meeting on 9/24/24 shall review the results of the audits and make additional recommendations based on the audit results. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *09/30/2024*

Implemented ([redacted] - 12/16/2024)

231f - Assessed Annually

17. Requirements

2600.
231.f. In addition to the requirements in § 2600.225 (relating to initial and annual assessment), the resident shall also be assessed annually for the continuing need for the secured dementia care unit.

231f - Assessed Annually *(continued)*

Description of Violation

The annual medical evaluation for resident #6, completed [redacted], does not include the resident's need for a secured dementia care unit.

Plan of Correction ***Accept ([redacted] - 09/26/2024)***

Resident #6 DME was corrected by the Health Care Director, in consultation with the resident's physician on [redacted].

On 9/19/24, the Residence Director or designee shall educate the Health Care Director, Assistant Health Care Director and Memory Care Director on regulation 231f. Documentation of this training shall be kept.

By 9/30/24, the Health Care Director, or designee will audit current memory care resident's charts for compliance with regulation 231f. Beginning 10/1/24, the Residence Director will review annual DMEs of memory care residents to ensure compliance with 231f.

Beginning at the next QMPI meeting on 9/24/24, shall review the results of the audits and make additional recommendations based on the audit results. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *09/30/2024*

Not Implemented ([redacted] - 12/16/2024)

234a - Admission Support Plan

18. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #6 was admitted to the SDCU on [redacted]. However, the resident's initial support plan was completed on [redacted]. Also, the resident's support plan was not updated to ensure the resident is still cognitively capable to use the swimming pool, as indicated in a letter dated [redacted]

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

On 8/6/24, health care director, or designee, reviewed Resident #6 initial RASP and noted that the RASP was conducted late and updated as indicated.

On 9/17/24 the Residence Director, or designee educated the Health Services Director and the Assistant Health Services Director on regulation 234a.

By 9/30/24 the Health Services Director, or designee audited current SDCU records for timely completion of the initial RASP and for accurate documentation of resident's cognitive status. Beginning 10/1/24, the Residence Director or designee will review all initial RASPs for timely and accurate documentation.

Beginning at the next QMPI meeting on 9/24/24, shall review the results of the audits and make additional

234a - Admission Support Plan (continued)

recommendations based on the audit results. Documentation shall be kept.

The Residence Director and/or Designee will ensure that within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.
Support plans identified in audit will be corrected by 10/31/2024.

Please note that we have also attached supporting documentation for all other citations here.

Licensee's Proposed Overall Completion Date: *10/31/2024*

Implemented ([redacted] - 12/16/2024)

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

Facility Information

Name: *RIDGECREST PERSONAL CARE & MEMORY CARE* **License #:** *45217* **License Expiration:** *09/15/2024*

Address: *8870 DUNCAN AVENUE, PITTSBURGH, PA 15237*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *CA SENIOR MCCANDLESS OPERATOR LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date:** *06/19/2020* **Issued By:** *Township of McCandless*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *180* **Waking Staff:** *135*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date:** *10/18/2024*

Inspection Dates and Department Representative

10/18/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *211* **Residents Served:** *134*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *1st floor* **Capacity:** *35* **Residents Served:** *27*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *134*

Diagnosed with Mental Illness: *6*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *46*

Have Physical Disability: *0*

Inspections / Reviews

10/18/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/28/2024*

Inspections / Reviews *(continued)*

12/02/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/17/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/06/2024*

12/12/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/17/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *12/17/2024*

12/19/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/17/2024*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

42b - Abuse

1. Requirements

2600.
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

Resident #1, resides in the Memory Care Neighborhood and has a diagnosis of dementia. According to the assessment, dated [redacted], the resident has a history of falls and is unsteady on [redacted] feet. In addition, the resident is assessed as needing total physical assistance with using the bathroom, and requires incontinence care and cleansing after an incontinent episode and direct care staff are to check on on [redacted] frequently. Resident #1 utilizes pull-ups.

According to a video recording provided by the family, the frequent checks and regular incontinent checks were not provided on [redacted]. The resident was left alone in [redacted] room from approximately 12:30 pm, when direct care staff provided assistance to the bathroom, until 4:20 pm when a family member entered the room. Resident #1 can be seen in the video, emerging from the bathroom at approximately 2:40 pm, holding a pull-up in [redacted] right hand. The resident fell to the floor as [redacted] struggled to put the pull-up back on.

When the resident's family arrived, they found the resident on the floor bleeding from the head, and summoned staff. Staff assessed the resident, called hospice, and waited for the hospice nurse to come in assess the resident and give direction regarding sending [redacted] out to the hospital. EMS was called to the home at [redacted] and they transferred resident #1 to the hospital where [redacted] was admitted with a diagnosis of [redacted].

The home failed to supervise and assist the resident with care needs from approximately 12:30 pm until summoned by the resident's family member at approximately 4:20 pm, resulting in resident falling and sustaining a serious bodily injury.

REPEAT VIOLATION: 1/30/24 et al.

Plan of Correction ***Directed ([redacted] - 12/11/2024)***

Resident# 1 returned to the residence on [redacted], Health Care Director reviewed RASP for interventions related to resident's fall risk on [redacted].

On 10/19/2024, Health Care Director immediately educated clinical associates that were working regarding following planned resident specific interventions and abuse prevention. Documentation shall be kept. No other residents had an incident, as per observations/conversations by Health Care Director on 10/19/24.

By 12/16/24, Health Care Director or designee shall educate current associates regarding the abuse prevention policy and following resident specific planned interventions. Documentation shall be kept.

Each shift, direct care staff will be monitored by the HCD/AHCD/Nurse/Medication Technician and/or designee during their working shifts to ensure all have completed their assigned care for residents per the resident assessment and care plan; and to assess for any suspicion of abuse neglect and or exploitation and report any occurrences immediately to the administrator or immediate manager/designee. The HCD/AHCD/Nurse/Med tech and/or designee will be present during care with assistive devices to ensure staff are prompt and proficient with assisting residents with mobility needs; observations/assistance provided will be documented on a designated observation form to be reviewed weekly X 6 weeks by the HCD and/or administrator. Documentation shall be kept.

42b - Abuse (continued)

Beginning 11/18/2024, Health Care Director, or designee, shall Interview/observe 5 residents weekly for 4 weeks to ensure residents are receiving planned resident specific interventions and are free from abuse. Health Care Director, or designee, shall immediately intervene should resident specific intervention not be follow and/or potential abuse is identified.
Audits to be completed by Health Care Director or designee 3 X per week for 3 weeks, 1 X weekly for 2 weeks beginning 11/18/24, on care giver task sheets to ensure residents are being supervised and assisted with care needs as needed.

The administrator will implement procedures that ensure compliance with §2600.42(b). The procedures will include, at a minimum, monthly administrator or designee interviews with at least 4 residents regarding care and treatment, including assistance with incontinence care, bathing, repositioning and bathing. Results of audit shall be reviewed in the next QMPI meeting on 12/18/24 and recommendations shall be followed. Documentation will be kept.

Proposed Overall Completion Date: 12/16/2024

Directed Completion Date: *12/16/2024*

Not Implemented ([redacted] - 12/19/2024)