

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

February 25, 2025

[REDACTED]  
HERITAGE GROVE AT INDIANA LLC  
[REDACTED]

RE: HERITAGE GROVE AT INDIANA  
1703 WARREN ROAD  
INDIANA, PA, 15701  
LICENSE/COC#: 45516

[REDACTED],  
As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/03/2025 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: HERITAGE GROVE AT INDIANA License #: 45516 License Expiration: 02/13/2025  
 Address: 1703 WARREN ROAD, INDIANA, PA 15701  
 County: INDIANA Region: WESTERN

**Administrator**

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

**Legal Entity**

Name: HERITAGE GROVE AT INDIANA LLC  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: C-2 LP Date: 01/24/1994 Issued By: L&I

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 55 Waking Staff: 41

**Inspection Information**

Type: Partial Notice: Unannounced BHA Docket #:  
 Reason: Complaint, Incident Exit Conference Date: 01/03/2025

**Inspection Dates and Department Representative**

01/03/2025 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**  
 License Capacity: 80 Residents Served: 33

**Secured Dementia Care Unit**  
 In Home: Yes Area: SDCU Capacity: 40 Residents Served: 12

**Hospice**  
 Current Residents: 7

**Number of Residents Who:**  
 Receive Supplemental Security Income: 4 Are 60 Years of Age or Older: 33  
 Diagnosed with Mental Illness: 1 Diagnosed with Intellectual Disability: 0  
 Have Mobility Need: 22 Have Physical Disability: 0

**Inspections / Reviews**

01/03/2025 Partial  
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 02/02/2025

01/31/2025 - POC Submission  
 Submitted By: [REDACTED] Date Submitted: 02/17/2025  
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 02/07/2025

Inspections / Reviews *(continued)*

02/11/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/17/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 02/17/2025

02/25/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 02/17/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

16c - Written Incident Report

1. 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

On [redacted] at approximately 1:58a.m., resident [redacted] was found in [redacted] bed with a laceration over [redacted] left eye. Resident [redacted] was transported to Indiana Regional Medical Center where [redacted] arrived with the chief complaint of “rolled over in bed, hit head on nightstand, laceration above left eye”. However, the incident was not reported to the department until [redacted], at 10:00 a.m.

REPEAT VIOLATION, [redacted], et al

Plan of Correction

Accept [redacted] 02/11/2025)

1.20.25 Old administrator is no longer employed at the community. 1.21.25 New administrator will conduct a thorough review of Resident [redacted] apartment to identify and mitigate any potential hazards. Resident [redacted] received all necessary medical follow-ups and care post incident.

2.12.25 Administrator will conduct a mandatory staff wide training on incident reporting procedures, emphasizing the importance of timely reporting within 24- hour window. Administrator and or resident care coordinator will conduct periodic refresher courses to reinforce the staff’s understanding of compliance regulations.

2.13.25 Administrator and Resident Care Coordinator will establish a routine auditing process to review incident reports and ensure compliance with reporting timelines, implementing a better tracking system to document incidents and the corresponding reporting dates to monitor adherence to the 24-hour requirement. Maintain open and transparent communication with the Department, providing regular updates on corrective actions taken and progress made. Administrator will submit weekly updates to the department as requested by DHS.

Licensee's Proposed Overall Completion Date: 02/10/2025

Implemented [redacted] - 02/25/2025)

42b - Abuse

2. 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 [redacted] was prescribed [redacted] tablet- take one tablet orally twice daily as needed for anxiety. However, resident [redacted] was administered a total of 5 doses of medication in a 24-hour period to include the following:  
On [redacted] at 5:46 a.m., staff member A administered a dose of [redacted] to resident [redacted], however did not document the administration on the residents November 2024 Medication Administration Record (MAR).  
On [redacted] at 7:13 a.m., staff member B administered a dose of [redacted] to resident [redacted].  
On [redacted] at 9:21 p.m., staff member C administered a dose of [redacted] to resident [redacted].  
On [redacted], at 11:46 p.m., staff member A administered a dose of [redacted] to resident [redacted].  
On [redacted], at 5:26 a.m., staff member A administered a dose of [redacted] to resident [redacted].

42b Abuse (continued)

Multiple interviews indicate that staff person A administered the medication to resident [REDACTED] inconsistent with the prescriber's order in order to keep the resident from ringing [REDACTED] call bell at night and to sedate the resident.

Plan of Correction

Accept [REDACTED] - 02/11/2025)

11.25.25 Employee A was terminated by the administrator after incident that involved Resident [REDACTED]. Resident Care Coordinator conducted a medical assessment with resident [REDACTED] PCP to ensure no adverse effects from the overmedication. Attached is Employee A term doc.

1.30.25 Outside agency came in and conducted a mandatory medtech staff training to go over what is a PRN, how to avoid medication errors, how if it's not used appropriately it's considered a chemical restraint which falls under abuse and neglect. 2.12.25 Administrator will conduct a mandatory staff wide training on residents rights.

2.13.24 Administrator and Resident Care Coordinator will establish a routine auditing process to review medication administration records for accuracy and compliance. Administrator and Resident Care Coordinator will implement a tracking system in conjunction with QuickMar to monitor the administration of PRN medications and ensure adherence to prescribed dosages. Administrator will maintain open communication with DHS providing regular updates on corrective actions taken and progress made. Administrator will submit weekly updates to the department as requested by DHS.

Licensee's Proposed Overall Completion Date: 02/10/2025

Implemented [REDACTED] - 02/25/2025)

187a - Medication Record

3. Requirements

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident [REDACTED] was prescribed [REDACTED] empty tablet take one tablet orally twice daily as needed for anxiety. On [REDACTED], staff member A administered one dose of [REDACTED] to resident Harry at 5:46 a.m. However, the staff member A's initials were not indicated on the resident [REDACTED] November 2024, medication administration record's corresponding date / time field.

Plan of Correction

Accept [REDACTED] - 02/11/2025)

11.25.25 Employee A was terminated by the administrator after incident that involved Resident [REDACTED]. Administrator and Resident Care Coordinator conducted a review of Resident [REDACTED] medications to ensure all dose. Attached in termination record.

1.30.25 Outside agency came in and conducted a mandatory medtech staff training to go over what is a PRN, how to avoid medication errors, proper medication administration and documentation procedures. Administrator and Resident Care Coordinator emphasize on the importance of accurate record keeping in QuickMar and the consequences of medication errors.

2.13.25 Administrator and Resident Care Coordinator will establish a routine weekly auditing process to review medication administration records for accuracy, compliance, and to identify any discrepancies. Administrator will

187a Medication Record (continued)

also keep open and transparent communication with DHS providing regular updates on corrective actions taken and progress made. Administrator will submit weekly updates to the department as requested by DHS.

Licensee's Proposed Overall Completion Date: 02/10/2025

Implemented [redacted] - 02/25/2025)

187d - Follow Prescriber's Orders

4. Requirements

2600.

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

Description of Violation

Resident [redacted] was prescribed [redacted] tablet take one tablet orally twice daily as needed for anxiety. However, resident [redacted] was administered a total of 5 doses of medication in a 24 hour period to include the following: On [redacted] at 5:46 a.m., staff member A administered a dose of [redacted] to resident [redacted] however did not document the administration on the residents November 2024 Medication Administration Record (MAR). On [redacted] at 7:13 a.m., staff member B administered a dose of [redacted] to resident [redacted]. On [redacted], at 9:21 p.m., staff member C administered a dose of [redacted] to resident [redacted]. On [redacted], at 11:46 p.m., staff member A administered a dose of [redacted] to resident [redacted]. On [redacted], at 5:26 a.m., staff member A administered a dose of [redacted] to resident [redacted].

Multiple interviews indicate that staff person A administered the medication to resident [redacted] inconsistent with the prescriber's order in order to keep the resident from ringing [redacted] call bell at night and to sedate the resident.

Plan of Correction

Accept [redacted] - 02/11/2025)

11.25.25 Employee A was terminated by the administrator after incident that involved Resident [redacted]. Resident Care Coordinator conducted a medical assessment with resident [redacted] PCP to ensure no adverse effects from the overmedication. Resident Care Coordinator and Administrator implemented close monitoring and documentation of medication administration for Resident [redacted] and other residents who require PRN medications. Attached is Employee term doc.

1.30.25 Outside agency came in and conducted a mandatory medtech staff training to go over what is a PRN, how to avoid medication errors, proper documentation of a medication. Administrator emphasize the importance of adhering strictly to prescriber's orders and the risks associated with overmedication.

2.13.24 Administrator and Resident Care Coordinator will implement close monitoring and documentation. Administrator and or Resident Care Coordinator will conduct periodic mandatory refreshers course and competency assessments to reinforce proper practices. Administrator will maintain open communication with DHS providing regular updates on corrective actions taken and progress made. Administrator will submit weekly updates to the department as requested by DHS.

Licensee's Proposed Overall Completion Date: 02/10/2025

Implemented [redacted] - 02/25/2025)

202 - Prohibitions

5. Requirements

202 - Prohibitions (*continued*)

2600.

202. The following procedures are prohibited:

4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.

**Description of Violation**

Resident [REDACTED] was prescribed [REDACTED] tablet- take one tablet orally twice daily as needed for anxiety. However, resident [REDACTED] was administered a total of 5 doses of medication in a 24-hour period to include the following:

On [REDACTED] at 5:46 a.m., staff member A administered a dose of [REDACTED] to resident [REDACTED] however did not document the administration on the residents November 2024 Medication Administration Record (MAR).

On [REDACTED] at 7:13 a.m., staff member B administered a dose of [REDACTED] to resident [REDACTED]

On [REDACTED], at 9:21 p.m., staff member C administered a dose of [REDACTED] to resident [REDACTED]

On [REDACTED], at 11:46 p.m., staff member A administered a dose of [REDACTED] to resident [REDACTED]

On [REDACTED], at 5:26 a.m., staff member A administered a dose of [REDACTED] to resident [REDACTED].

Multiple interviews indicate that staff person A administered the medication to resident [REDACTED] inconsistent with the prescriber's order in order to keep the resident from ringing [REDACTED] call bell at night and to sedate the resident.

**Plan of Correction**

Accept ( [REDACTED] - 02/11/2025)

11.25.25 Employee A was terminated by the administrator after incident that involved Resident [REDACTED] Resident Care Coordinator conducted a medical assessment with resident [REDACTED] PCP to ensure no adverse effects from the overmedication. Resident Care coordinator also implemented close monitoring and documentation of medication administration for Resident [REDACTED] and other residents who require PRN medications. Attached is Employee A.

1.30.25 outside agency came in and schedule a mandatory medtech staff training on the prohibition of chemical restraints and proper medication administration processes. 2. 12.25 Administrator will be conducting an all staff mandatory training on residents rights.

2.13.25 Administrator and Resident Care Coordinator will implement close monitoring and documentation. Administrator and or Resident Care Coordinator will conduct periodic mandatory medtech refreshers course and competency assessments to reinforce proper practices. Administrator will maintain open communication with DHS providing regular updates on corrective actions taken and progress made. Administrator will submit weekly updates to the department as requested by DHS.

Licensee's Proposed Overall Completion Date: 02/10/2025

Implemented ( [REDACTED] - 02/25/2025)