

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

April 1, 2025

[REDACTED]  
MERAKEY PENNSYLVANIA  
[REDACTED]

RE: MERAKEY PENNSYLVANIA  
108 CEDARWOOD CIRCLE  
RUSSELLTON, PA, 15076  
LICENSE/COC#: 43842

[REDACTED],  
As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/21/2025 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: MERAKEY PENNSYLVANIA License #: 43842 License Expiration: 08/15/2025  
Address: 108 CEDARWOOD CIRCLE, RUSSELLTON, PA 15076  
County: ALLEGHENY Region: WESTERN

**Administrator**

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

**Legal Entity**

Name: MERAKEY PENNSYLVANIA  
Address: [REDACTED]  
Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

**Staffing Hours**

Resident Support Staff: Total Daily Staff: 10 Waking Staff: 8

**Inspection Information**

Type: Partial Notice: Unannounced BHA Docket #:  
Reason: Complaint Exit Conference Date: 02/21/2025

**Inspection Dates and Department Representative**

02/21/2025 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: 10 Residents Served: 10

**Secured Dementia Care Unit**

In Home: No Area: Capacity: Residents Served:

**Hospice**

Current Residents: 0

**Number of Residents Who:**

Receive Supplemental Security Income: 6 Are 60 Years of Age or Older: 5  
Diagnosed with Mental Illness: 10 Diagnosed with Intellectual Disability: 0  
Have Mobility Need: 0 Have Physical Disability: 0

**Inspections / Reviews**

02/21/2025 Partial

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/06/2025

03/07/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: 04/01/2025  
Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/13/2025

Inspections / Reviews *(continued)*

03/13/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/01/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 04/01/2025

04/01/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/01/2025

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] resident [redacted] left the home to go to church; however, did not return to the home until [redacted]. A missing persons report was filed on [redacted]. Additionally, on [redacted], resident [redacted] left the home to go to church again; however, did not return to the home until [redacted]. A missing persons report was filed on [redacted]. However, neither of these unexplained absences were reported to the Department.

Plan of Correction

Directed [redacted] 03/13/2025)

1. The incidents cited were successfully reported to the Office of Behavioral Health (Allegheny County), but not to the Department. The PCH Administrator completed & submitted BHSL Incident Reports for the specified incidents that occurred in November 2024 & February 2025 on March 11, 2025.
2. The PCH Administrator updated the site's incident reporting binder to include the appropriate incident reporting policies and procedures on 2/25/25, including lists of reportable incidents to both the county and the Department, a copy of the Incident Report Form, and instructions on how to submit an incident report within the required timeframes.
3. The PCH Administrator reviewed the updated incident management policies and procedures with all PCH staff at the facility's team meeting on 2/27/25. The review is documented in the meeting agenda that's attached.
4. Moving forward, all PCH staff will continue to notify the Site Supervisor and/or PCH Administrator of any emergencies or necessary incident reports for all entities (internal, County & State) as soon as the incident occurs (Administrator must be notified by or before the witnessing staff ends their shift) so the PCH Administrator can ensure the correct policies and procedures are followed and submitted to the correct entities within required timeframes. The PCH Administrator and/or Site Supervisor will ensure all PCH staff follow the requirements regarding documentation and incident reporting for both internal incidents through Avatar and Office of Behavioral Health (county) as necessary. For appropriate incidents, PCH Administrator will be the designated person to complete any & all BHSL Incident Reports as soon as they're notified of the incident and will have the Incident report submitted within 24 hours of the incident occurring. The Administrator and/or site supervisor will also check the incident report binder and communication logs daily to ensure incident reports were submitted to the appropriate entities within 24 hours of the incident occurring. (DIRECTED: The daily review of the incident report binder and communication logs shall begin on 3/17/25. [redacted] 3/13/25).
5. The PCH Administrator will review & discuss all PCH incident reports (internal, county & state) at least once per month during the monthly ABH Residential PQI meetings. The PQI meeting for March was held on March 11, 2025 and the next PQI meeting is scheduled for April 1, 2025. The uploaded PQI Spreadsheet will be used to document and track these monthly reviews.

Proposed Overall Completion Date: 04/01/2025

Directed Completion Date: 04/01/2025

Implemented ([redacted] 04/01/2025)

88a - Surfaces

2. 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

Numerous large dark areas, which appear to be mold, were present on the floors, walls and along the bottom of the shower doors in the following shower stalls:

- The shower stall in the shared bathroom between bedrooms [redacted] and [redacted]
- The shower stall in the shared bathroom between bedrooms [redacted] and [redacted]

Plan of Correction

Accept [redacted] - 03/13/2025)

1. Direct care staff thoroughly cleaned the identified showers and took photos of the clean showers on 3/3/2025.
2. The PCH Administrator reviewed bathroom cleanliness requirements with all PCH staff during February's PCH staff meeting held on 2/27/25. This review is documented in the meeting agenda.
3. The Administrator is collaborating with the Merakey Facilities team to have both bathrooms remodeled, and the program has successfully obtained cost estimates as of 2/24/25. Until remodeling is completed for both shared bathroom stalls, Direct Care Staff will complete routine bi-weekly facility & resident bedroom checks utilizing the Bi-weekly Facility Check template, which reviews that floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. PCH Staff will report any cleanliness issues found to the Supervisor and/or Administrator immediately to be corrected in a timely manner. The first of these Bi-Weekly Facility checks began on March 9, 2025 and a copy of the facility check template that's attached includes everything staff have & will continue to assess during these routine checks. The next round of facility checks will take place during the week of March 23-March 30, 2025.
4. The PCH Administrator will review Bi-Weekly Facility Checklists on a monthly basis and will report any issues to the Facilities team for corrective action/repair. Any trending facility issues and reviews of PCH facility checks will be discussed and completed by the PCH administrator at the ABH Residential Monthly PQI meetings (PQI meeting documentation form attached). The 1st review of these checks by the PCH Administrator took place during March's PQI Meeting on March 11, 2025 and the next review will take place during next month's PQI meeting scheduled for April 1, 2025.

Proposed Overall Completion Date: 04/01/2025

Licensee's Proposed Overall Completion Date: 04/01/2025

Implemented [redacted] - 04/01/2025)

101j1 - Mattress Fire Retardant

3. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

The right leg at the foot of resident [redacted] bed was in disrepair, causing the bed to tilt and the box spring to touch the ground when resident [redacted] sits on [redacted] bed.

101j1 Mattress Fire Retardant (continued)

Plan of Correction

Accept [redacted] - 03/13/2025)

1. The Administrator requested estimates from Butler Human Services (BHS) for a new bedframe for Resident [redacted] bedroom on 3/3/25 and the order was finalized/placed on 3/6/25. The estimated Delivery Date provided on the BHS Order Acknowledgement Form is March 14, 2025 - March 28, 2025. The New frame will be installed upon delivery by BHS delivery staff who deliver the furniture, which is also indicated on the attached order acknowledgement form.
2. The PCH Administrator reviewed bedroom requirements and subsequent reporting procedures in relation to the bedroom & facility checks with all PCH staff at February's PCH staff meeting on 2/27/25. This review is documented in the meeting agenda that has been attached.
3. Direct care staff completed the 1st routine bi weekly facility & bedroom checks for all 10 resident bedrooms and the facility on March 9, 2025 utilizing the Bi weekly Facility & bedroom Check templates, which includes reviews that floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards and reviews resident bedframes. All other resident beds inspected at that time to ensure compliance with 2600.101j1. Staff completing the checks will report any damaged furniture/repair needs that were found during the check to the Supervisor and/or PCH Administrator the same day that the check was performed so the PCH Administrator can ensure repairs/needs are fixed in a timely manner. PCH staff working the day and evening shifts are responsible for completing the Bi weekly room & facility checks, which will always be performed on all 10 of the residents bedrooms & bathrooms, as well as the facility itself on a routine, bi weekly basis, documented on the Facility & Bedroom Check forms & filed in the Routine Facility Check binder. The next Bi weekly room checks will take place the week of March 23 - March 30, 2025.
4. The PCH Administrator will review Bi Weekly Facility Checklists monthly beginning on April 1, 2025 and will report any issues to the Facilities team for corrective action, should there be any that haven't already been addressed at that time. Any trending facility issues will be discussed and documented at the PQI meetings monthly. The first review of the facility & bedroom checks performed by the PCH Administrator took place at the monthly PQI meeting held on March 11, 2025 and the next review will take place during next month's PQI meeting scheduled for April 1, 2025.

Proposed Overall Completion Date: 04/01/2025

Licensee's Proposed Overall Completion Date: 04/01/2025

Implemented [redacted] - 04/01/2025)

141b1 - Annual Medical Evaluation

4. Requirements

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident [redacted] most recent medical evaluation was completed on [redacted]

Plan of Correction

Directed [redacted] - 03/13/2025)

1. Resident [redacted] attended [redacted] PCP appointment where [redacted] had [redacted] annual medical evaluation on [redacted] and the PCH Administrator and RN completed a chart audit of resident [redacted] chart on [redacted] & [redacted] (chart audit form and updated medical evaluation are attached)
2. Moving forward, the Administrator & RN developed a tracking table on 3/3/25 (Assessment Tracking Table attached) for the RN to closely monitor pertinent updates for each resident, including annual medical evaluations.

141b1 Annual Medical Evaluation (continued)

The RN will schedule all annual medical evaluations at least 30 days in advance of their expiration dates. In the event of a staffing vacancy, the Administrator or their designee will fulfill this requirement. The RN will review the tracking chart on a monthly basis. The 1st Assessment Tracking Table review was performed on 3/3/25 by the RN and the will RN will perform their next review of the tracking table the week of April 1 April 4, 2025. The PCH Administrator and RN met on 3/10/25 for individual supervision to review updated responsibilities, timelines and tasks associated with the table [REDACTED] created to track/monitor assessment dates (documentation of supervision attached).

3. The Administrator & RN or their designee(s) will continue to complete routine Quarterly Resident Chart Audits using the PCH Chart Audit Form on all 10 resident charts on a quarterly basis. The Administrator and RN will have all 10 of the residents' charts audited by or before March 28, 2025 and will conduct the next round of chart audits for all 10 resident charts in June of 2025. If any medical evaluations are found to be untimely or missing during any of the quarterly audits, the medical evaluation(s) will be immediately scheduled and The Administrator will schedule an immediate supervision meeting with the RN to review discrepancies, identify the source of the issue and document any appropriate action taken. The PCH Administrator reviewed these updates with the RN in an individual supervision meeting held on March 10, 2025.

DIRECTED: By 4/1/25: The home shall conduct a quality management review, which includes a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [REDACTED] 3/13/25

Proposed Overall Completion Date: 04/01/2025

Directed Completion Date: 04/01/2025

Implemented [REDACTED] 04/01/2025)

225c - Additional Assessment

5. Requirements

2600.

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

- 1. Annually.

Description of Violation

On [REDACTED], resident [REDACTED] left the home to go to church; however, did not return to the home until [REDACTED]. A missing persons report was filed on [REDACTED]. Additionally, on [REDACTED], resident [REDACTED] left the home to go to church again; however, did not return to the home until [REDACTED]. A missing persons report was filed on [REDACTED]. However, resident [REDACTED] most recent assessment, dated [REDACTED] indicates resident [REDACTED] requires no supervision in or out of the home.

Plan of Correction

Directed [REDACTED] - 03/13/2025)

- 1. Resident [REDACTED] RASP was updated on [REDACTED] to reflect updated supervision information related to [REDACTED] recent elopement attempts. The Administrator revised the supervision sections of their RASP to identify/explain the events & reasons leading to the significant changes in their RASP and explains the PCH's plans to help meet the new supervision goals indicated in the updated support plan.
- 2. The Administrator and RN meet with the resident on 2/28/25 and 3/2/25 to provide education regarding Client Rights and PCH House Rules. The RN completed an Independent Progress Note, signed by the resident, that documents this review; specifically, clarifying expectations and procedures around the resident's right to go out in the community as long as it's in compliance with PCH House Rules, which includes taking prescribed medications at

225c - Additional Assessment (continued)

prescribed times and communicating all plans of leaving facility with direct care staff, as well as health & safety risks associated with leaving the facility without informing staff.

3. The Administrator provided the Independent Progress Note template to all staff during the staff meeting on 2/27/25, along with instructions & expectations for direct care staff to complete the note with the resident at least weekly (staff meeting documentation attached). The RN will review the independent progress notes for resident #1 weekly and report any issues to PCH administrator immediately. When staffing permits, the program will also provide the resident with transportation to/from the community outings.

4. The Administrator and RN or their designee(s) will complete routine quarterly Chart Audits of all 10 of the PCH resident's charts using the PCH Chart Audit Form, in which the audits have already began and will be completed by the PCH Administrator and RN no later than March 28, 2025. As of March 10, 2025, The Chart Audit templates have been updated to also include a review of each of the residents' current RASPs to ensure the support plans are accurate and reflect/address all significant changes with the residents' needs, if any, that have may have occurred since it was last updated. The next round of quarterly chat audits will take place in June of 2025.

5. Regarding the PCH procedures for updating resident's RASP's, PCH Administrator and/or designees are as follows: Initial Support Plans need to be completed within 15 days of a new resident's admission to the PCH and annually thereafter. Outside of the initial & annual support plan assessments/updates, the PCH Administrator and/or designees are required to update the resident's RASP any time there's a "significant change(s)" to the resident's needs to ensure that their support plan addresses any new needs of the resident that have been specified. When there is a "significant change" in a resident's needs, the RN will immediately notify the Administrator. The Administrator will schedule a meeting with the RN and the resident to collaboratively review and update the resident's RASP to address and account for any/all significant changes that were identified.

DIRECTED: By 4/1/25: The home shall conduct a quality management review, which includes a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 3/13/25

Proposed Overall Completion Date: 03/28/2025

Directed Completion Date: 04/01/2025

Implemented [redacted] - 04/01/2025)