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 **July 30, 2025** until **July 30, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **452170**

ISSUING OFFICER

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 628 – 04/23

Pennsylvania
Department of Human Services

Emailing Date: July 30, 2025

[redacted]
CA Senior McCandless Operator LLC
[redacted]

RE: Ridgecrest Personal Care & Memory Care
8870 Duncan Avenue
Pittsburgh, Pennsylvania 15237
License/COC #: 452170

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on April 16-18, 2025, May 2, 2025 and July 24, 2025, and the corrections you have made after our inspections, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

Facility Information

Name: *RIDGECREST PERSONAL CARE & MEMORY CARE* **License #**: *45217* **License Expiration**: *07/13/2025*

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

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

Administrator

Name: [redacted]

Legal Entity

Name: *CA SENIOR MCCANDLESS OPERATOR LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *06/19/2020* **Issued By**: *Township of McCandless*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *219* **Waking Staff**: *164*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional, Incident* **Exit Conference Date**: *04/21/2025*

Inspection Dates and Department Representative

04/16/2025 - On-Site: [redacted]
04/17/2025 - On-Site:
04/18/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *211* **Residents Served**: *161*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *1st Floor* **Capacity**: *35* **Residents Served**: *31*

Hospice

Current Residents: *17*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *160*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *58*
Have Physical Disability: *0*

Inspections / Reviews

04/16/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/14/2025*

05/13/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/28/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/19/2025*

05/19/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/28/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/30/2025*

07/28/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *05/28/2025*

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

25b - Contract Signatures

1. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract for resident #1, dated [redacted]/24, is not signed by the resident.

The resident-home contract for resident #2, dated [redacted]25, is not signed by the resident.

The resident-home contract for resident #3, dated [redacted]/25, is not signed by the resident.

Plan of Correction ***Directed [redacted] - 05/19/2025)***

-Business office Manger had home contracts signed for Residents #1, #2, and #3 on 4-17-2025.
-The Regional Healthcare Director provided training to Interim Director, Business Office Manager and Sales Team regarding 2600.25.b on 5-8-2025, documentation shall be kept in accordance with regulation 2600.65i.
-The Business Office Manager and/or Designee will audit current resident's home contracts to assure they are signed by the Resident and resident's designated person, if appliable by 5-30-2025. Any contracts found not to be compliant will be signed by resident at time of audit.
-Beginning 5/12/25, the Interim Director and/or Designee will audit new resident home contracts weekly X 4 weeks prior to filing to assure contracts are signed by the resident and designated person, if applicable.
-Beginning 5/12/25, a new move in checklist shall be completed on new move in charts by the Business Office Manager.
- To ensure consistent adherence to Regulation 2600.25b, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/21/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. [redacted] 5/19/25).

Proposed Overall Completion Date: 05/30/2025

Directed Completion Date: *05/30/2025*

Implemented ([redacted] - 07/28/2025)

54a - Direct Care Staff

2. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

No documentation is present indicating direct care staff person A, hired on [redacted]23, has a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

54a - Direct Care Staff (continued)

Plan of Correction ***Directed [redacted] - 05/19/2025)***

-Staff person A applied for a copy of [redacted] transcripts from [redacted] College, Staff person A removed from direct care assignment on 5/13/25 , will perform kitchen/dining/housekeeping duties until transcripts received.
-The Regional Director of Operations or designee completed an in-service on 2600.54.a. to the Business Office Manager, Customer Service Advocate, Interim Director on 5-8-2025, documentation shall be kept in accordance with 2600.65i.
-The Business Office Manager and/or Designee will audit current direct care staff files to assure they are compliant with 2600.54.a by 5-30-25.
-Beginning 5/12/25, The Interim Director and/or Designee shall audit new hire files weekly X 4 weeks to assure direct care staff have documentation applicable to 2600.54.a.
-Beginning 5/12/25, a new hire checklist shall be completed on new hire files by the Business Office Manager.
-To ensure consistent adherence to Regulation 2600.54a, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/21/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. [redacted] 5/19/25).

Proposed Overall Completion Date: 05/30/2025

Directed Completion Date: *05/30/2025*

Implemented [redacted] - 07/28/2025)

81b - Resident Personal Equipment

3. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 4/17/25 at approximately 2:00pm, the halo bedside mobility device attached to the left side of resident #6's bed was uncovered and had an opening that measured 4" x 6", posing an entrapment hazard.

Plan of Correction ***Directed [redacted] 05/19/2025)***

-On 4/18/25 the halo bedside device next to resident #6 bed was covered and resolved by the Maintenance Director.
-By 5/30/25, the Maintenance Director audited remaining resident bedside mobility aides to ensure adherence with regulation 2600.81b.
-The Interim Administrator, Maintenance and Clinical Staff re-educated by Regional Healthcare Director on this safety measure of regulatory guidelines by 5-8-2025, documentation shall be kept in accordance with 2600.65i.
-By 5/30/25, the interim administrator shall educate current staff on regulation 2600.81b, documentation shall be

81b - Resident Personal Equipment (continued)

kept in accordance with 2600.65i.
-Beginning 5/12/25, the Maintenance Director and/or Designee shall audit resident's bedside mobility aides weekly X 4weeks then monthly for proper installation and covering. This task added to monthly maintenance director duties in TELS. (DIRECTED: Each audit shall include a check of all bedside mobility devices to ensure they are clean, in good repair and free of hazards. [redacted] 5/19/25).
-To ensure consistent adherence to Regulation 2600.81b, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/21/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. [redacted] 5/19/25).

Proposed Overall Completion Date: 05/30/2025

Directed Completion Date: *05/30/2025*

Implemented [redacted] - 07/28/2025)

88a - Surfaces

4. 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

On 4/16/25 at approximately 11:00am, the left door of the double glass exit doors from the home's indoor pool area to the side patio would not securely close and latch into the door frame without significant force to pull/push it shut.

REPEAT VIOLATION: 8/5/2024, et. al.

Plan of Correction ***Directed [redacted] - 05/19/2025)***

-On 4/16/25, the Maintenance Director fixed the side patio door to the pool area so that it securely closed and latched in the door frame without significant force to pull/push it to shut.
-By 5/12/25, the Maintenance Director and/or Designee shall audit other self closing doors to assure they close and latch into the door frame, any further finding to be corrected at time of audit.
- The Regional Director of Operations and/or Designee will in-service the Maintenance Team on regulation 88.a. by 5/15/25, documentation shall be kept in accordance with 2600.65i.
-By 5/30/25, the Interim Administrator and/or designee shall educate current staff on regulation 2600.88a, documentation shall be kept in accordance with 2600.65i.
-Beginning 5/12/25, the Maintenance Director or designee shall audit self closing doors weekly X 4 weeks.
-Beginning 5/12/25, on a monthly basis, the Maintenance Director or designee shall inspect the entire home to ensure floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. This monthly inspection added to maintenance director responsibilities in TELS.
-To ensure consistent adherence to Regulation 2600.88a, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/21/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. (DIRECTED: The quality management review shall

88a - Surfaces (continued)

include a review of all items specified in 2600.26b. LM 5/19/25).

Proposed Overall Completion Date: 05/30/2025

Directed Completion Date: *05/30/2025*

Implemented [redacted] - 07/28/2025)

103f - Refrigerator/Freezer Temps

5. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 4/16/25 at approximately 11:00am, no thermometer was present in the silver chest freezer, located in the home's main kitchen.

Plan of Correction ***Directed [redacted] - 05/19/2025)***

-On 4/16/25, a thermometer was placed in the silver chest freezer in the main kitchen and resolved by the Chef.
-By 5/30/25, the Regional Director of Operations and/or designee will re-educate the Culinary Dept. on regulation 103.f. and the importance of monitoring temperature of food items, documentation shall be kept in accordance with 2600/65i.
-The Maintenance Director completed an audit on all freezers/refrigerators on 4/16/2025 and found all had thermometers present.
-Beginning 5/12/25, the Chef or Designee shall audit all freezers/refrigerators to assure thermometers are present weekly for 4 weeks then monthly going forward. (DIRECTED: The audits shall also include ensuring proper food handling temperatures are present in each refrigerator and freezer in accordance with 2600.103f. [redacted] 5/19/25).
-To ensure consistent adherence to Regulation 2600.103f, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/21/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. [redacted] 5/19/25).

Proposed Overall Completion Date: 05/30/2025

Directed Completion Date: *05/30/2025*

Implemented [redacted] - 07/28/2025)

141a 1-10 Medical Evaluation Information

6. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #2's medical evaluation, dated [redacted]/25, indicates resident #2 is prescribed a mechanical soft diet and a regular diet; however, does not indicate which foods should be served soft and which foods can be served regular.

Plan of Correction ***Directed[redacted] - 05/19/2025)***

-On 4-18-2025, Resident # 2's medical evaluation corrected by provider to indicate mechanical soft as proper diet for resident. RASP was also corrected on 4-18-2025 by the HCD. (DIRECTED: Within 24 hours of receipt of the plan of correction: The administrator shall ensure dietary staff are notified of resident #2's current mechanical soft diet. [redacted] 5/19/25).
-By 5/30/25, the Healthcare Director or designee shall audit remaining current resident medical evaluations to assure proper diet noted; non-compliant findings shall be corrected at time of audit.
-On 5-8-2025, the Regional Healthcare Director or Designee re-educated the Healthcare Director and Assistant Healthcare Director on regulation 2600.141a, documentation shall be kept in compliance with 2600.65i.
-Beginning 5-12-2025, the Healthcare Director or designee shall review newly completed/obtained medical evaluations prior to filing to ensure accuracy. (DIRECTED: The audits of newly-completed medical evaluations shall be conducted weekly. [redacted] 5/19/25).
-To ensure consistent adherence to Regulation 2600.141a, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/21/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. [redacted] 5/19/25).

Proposed Overall Completion Date: 05/30/2025

Directed Completion Date: *05/30/2025*

Implemented ([redacted] 07/28/2025)

141b1 - Annual Medical Evaluation

7. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #4's most recent medical evaluation was completed on [redacted]/24; however, resident #4's previous medical

141b1 - Annual Medical Evaluation (continued)

evaluation was completed on 11/8/23.

Plan of Correction ***Directed [redacted] - 05/19/2025)***

-Resident #4's annual medical evaluation is current, dated 12/17/24. Resident has an outside Medical Provider and was unable to get a timely appointment at the time the Medical Evaluation was due.
-The Regional Health Care Director re-educated the Clinical team on Regulation 141.b.1. on 5/8/25, documentation shall be kept in accordance with 2600.65i.
-By 5/30/25, the Health Care Director or Designee will audit current resident files for current medical evaluations, further findings to be corrected at time of audit.
-Beginning 5/30/25, a DME/RASP tickler file created by the Healthcare Director to track pending and upcoming medical evaluations.
-Beginning 5/30/25, the Interim Administrator and the Healthcare Director shall review the DME/RASP tickler weekly to ensure compliance with 2600.141b1.
-To ensure consistent adherence to Regulation 2600.141b1, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/21/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. [redacted] 5/19/25).

Proposed Overall Completion Date: 05/30/2025

Directed Completion Date: *05/30/2025*

Implemented [redacted] - 07/28/2025)

141b2 - Medical Evaluation Changes

8. Requirements

2600.
141.b.2. A resident shall have a medical evaluation: If the medical condition of the resident changes prior to the annual medical evaluation.

Description of Violation

Resident #3's most recent medical evaluation, completed on [redacted]25 due to a status change, only includes code numbers for resident #3's 10 diagnoses.

Plan of Correction ***Directed ([redacted] - 05/19/2025)***

-Diagnoses for the referring ICD -10 Codes for Resident #3s Medical Evaluation were added to the medical evaluation on 5-7-2025 by the Regional Healthcare Director.
-By 5/15/25, the Regional Health Care Director or Designee shall educate the Healthcare Director, Assistant Healthcare Director and Wellness Nurses on 2600.141.b.2, documentation shall be kept in accordance with 2600.65i.
-The Health Care Director and/or Designee will audit remaining resident files to assure that any diagnoses listed only in code are also written out by 5/30/25.
-Beginning 5/30/25, the Health Care Director or designee shall review newly obtained/completed medical evaluations for proper documentation prior to filing in resident's chart. (DIRECTED: The audits of newly-completed medical evaluations shall be conducted weekly.[redacted] 5/19/25).

141b2 - Medical Evaluation Changes (continued)

-To ensure consistent adherence to Regulation 2600.141b2, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/21/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. [redacted] 5/19/25).

Proposed Overall Completion Date: 05/30/2025

Directed Completion Date: *05/30/2025*

Implemented [redacted] - 07/28/2025)

171b5 - First Aid Kit

9. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

On 4/18/25, the first aid kit in the home's Ford Flex van did not include a thermometer or breathing shield.

Plan of Correction ***Directed [redacted] - 05/19/2025)***

-On 4/18/24, a thermometer and breathing shield was placed in the first aid kit in the Ford Flex Van by the Maintenance Director.
-The RDO and/or Designee will in-service the Maintenance, Life Enrichment and Clinical Administrative Teams on 171.b. by 5/15/25, documentation shall be kept in accordance with 2600.65i.
-On 4/18/25, the Maintenance Director audited all first aid kits to include both resident transport vehicles (Ford Flex and a van), no further issues noted.
-Beginning 5/12/25, the Maintenance Director or Designee will audit all first aid kits to include the kits in the 2 vehicles, this audit shall be performed weekly X 4 weeks, then monthly going forward. This task added to monthly Maintenance Director responsibilities in TELS.
-To ensure consistent adherence to Regulation 2600.171b5, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/21/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. [redacted] 5/19/25).

proposed Overall Completion Date: 05/30/2025

Proposed Overall Completion Date: 05/30/2025

Directed Completion Date: *05/30/2025*

Implemented [redacted] - 07/28/2025)

185a - Implement Storage Procedures

10. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 4/17/25 at 7:25pm, resident #8's glucometer indicated the resident's blood glucose was 219; however, was documented as 216 on resident #8's April 2025 medication administration record (MAR).

Plan of Correction ***Directed [redacted] - 05/19/2025)***

-The MAR for resident 8 was corrected to reflect the accuracy of the result from the blood glucose machine on 4/17/25 by the Healthcare Director.
-By 5/30/25, The Regional Health Care Director shall educate the associates who administer medications on regulation 2600.185a and proper documentation, documentation shall be kept in accordance with 2600.65i.
-Beginning 5/19/25, the Health Care Director or Designee shall randomly audit MAR entries of diabetic residents against the blood glucose machine weekly X 4 weeks, then monthly going forward. (DIRECTED: At least 3 different residents prescribed blood sugar checks shall be included in each audit. Documentation of the weekly audits shall be kept. [redacted] 5/19/25).
--To ensure consistent adherence to Regulation 2600.185a, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/21/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. [redacted] 5/19/25).

Proposed Overall Completion Date: 05/30/2025

Directed Completion Date: *05/30/2025*

Implemented ([redacted] - 07/28/2025)

187a - Medication Record

11. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
8. Frequency of administration.

Description of Violation

On 4/11/25, resident #8 was prescribed Lispro Kwikpen 100u/ml insulin-Inject subcutaneously twice daily before breakfast and dinner in accordance with the following sliding scale: <70-initiate hypoglycemia protocol; 70-130=0 units; 131-180=0 units; 181-240=2 units; 241-300=3 units; 301-350=4 units; 351-400=5 units; >400=6 units and call MD; however, resident #8's April 2025 MAR indicates the frequency of this order as "as needed".

187a - Medication Record *(continued)*

Plan of Correction ***Directed [redacted] - 05/19/2025)***

-The incorrect entry of the Sliding scale order to the E MAR was corrected by the Healthcare Director on 4-16-2025 at time of survey. It was inadvertently entered as PRN instead of routinely with blood glucose monitoring results for coverage.
-On 4/16/25, the Healthcare Director informed the provider, DHS reportable sent and family notified.
-On 4/18/25, the Regional Health Care Director educated the Healthcare Director and Assistant Healthcare Director on regulation 2600.187a, the importance of following PCP orders, accurate order entry/ approvals to the EMAR. Documentation shall be kept in accordance with 2600.65i.
-By 5/30/25, the Healthcare Director or designee shall educate associates who administer medication on regulation 2600.187a, process for updating resident MAR upon receipt of new orders, importance of following prescriber's orders, documentation shall be kept in accordance with 2600.65i.
- By 5/19/25, the Healthcare Director or designee will audit remaining sliding scale orders to ensure proper transcription.
-Beginning 5/12/25, the Healthcare Director or designee shall audit incoming new orders for transcription accuracy, this audit shall be performed weekly X 4 weeks. (DIRECTED: Documentation of the weekly audits shall be kept. [redacted] 5/19/25). Then, a random MAR audit on 10 residents monthly will be performed by the Healthcare Director or designee.
-To ensure consistent adherence to Regulation 2600.187a, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/21/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. [redacted] 5/19/25).

Proposed Overall Completion Date: 05/30/2025

Directed Completion Date: *05/30/2025*

Implemented [redacted] - 07/28/2025)

187d - Follow Prescriber's Orders

12. Requirements

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

Description of Violation

On 4/11/25, resident #8 was prescribed Lispro Kwikpen 100u/ml insulin-Inject subcutaneously twice daily before breakfast and dinner in accordance with the following sliding scale: <70-initiate hypoglycemia protocol; 70-130=0 units; 131-180=0 units; 181-240=2 units; 241-300=3 units; 301-350=4 units; 351-400=5 units; >400=6 units and call MD. However, according to resident #8's glucometer and April 2025 MAR, resident #8's blood glucose was only checked one time daily in the evenings from 4/12/25 through 4/17/25.

Also, according to resident #8's April 2025 MAR, no Lispro insulin was administered to resident #8 on the following evenings in accordance with current prescriber's order, dated 4/11/25:

- *On the evening of 4/12/25, resident #8's blood glucose was 234 and should have received 2 units of Lispro insulin*

187d - Follow Prescriber's Orders (continued)

- *On the evening of 4/13/25, resident #8's blood glucose was 270 and should have received 3 units of Lispro insulin*
- *On the evening of 4/14/25, resident #8's blood glucose was 197 and should have received 2 units of Lispro insulin*
- *On the evening of 4/15/25, resident #8's blood glucose was 390 and should have received 5 units of Lispro insulin*
- *On the evening of 4/16/25, resident #8's blood glucose was 201 and should have received 2 units of Lispro insulin*

REPEAT VIOLATION: 8/5/2024, et. al.

Plan of Correction ***Directed (- 05/19/2025)***

-On 4/16/25 at time of survey, the incorrect entry of the Sliding scale order to the E MAR was corrected by the Healthcare Director. It was inadvertently entered as PRN instead of routinely with blood glucose monitoring results for coverage.
- On 4/16/25, the Healthcare Director made the PCP aware, DHS reportable sent and family notified.
- On 4/23/25, the Regional Health Care Director educated the clinical team of nurses on Regulation 187.d, documentation shall be kept in accordance with 2600.65i.
-By 5/30/25, the Healthcare Director or designee shall educate staff who administer medications on regulation 2600.187d, following directions of the prescriber and use of the EMAR dashboard to ensure scheduled medication administration is completed. Documentation shall be kept in accordance with 2600.65i.
- By 5/15/25, the Health Care Director or Designee shall audit remaining residents with sliding scale orders to assure the orders are accurate and a review of the MARs to be conducted for missed medications/not following prescriber's orders.
-Beginning XXXXX, the Health Care Director or designee shall audit current MARs weekly X 4weeks for adherence to regulation 2600.187d, then audit 10 MARs monthly going forward. (DIRECTED: The weekly audits shall begin on 5/21/25, and shall include a review of at least 6 different residents each week to ensure compliance withy 2600.187d. Documentation of the weekly audits shall be kept. 5/19/25).
-To ensure consistent adherence to Regulation 2600.187d, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/21/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. 5/19/25).

Proposed Overall Completion Date: 05/30/2025

Directed Completion Date: *05/30/2025*

Implemented - 07/28/2025)

190c - Record of Training

13. Requirements

2600.

190c - Record of Training *(continued)*

190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The record of training for direct care staff person B's 2024 annual practicum from the Department-approved medication administration course does not include include the name/signature of the trainer or the date direct care staff person B successfully completed the 2024 annual practicum. These sections of the record of training are blank.

Plan of Correction ***Directed (- 05/19/2025)***

- On 4/17/25, The Regional Health Care Director/TTT signed Staff Person B's 2024 annual practicum observations completed by the certified practicum observer.
-On 4/17/25, the Regional Healthcare Director performed a review of the current med tech's files, no further findings noted.
- By 5/30/25, the Regional Director of Operations shall educate the Regional Healthcare Director and the Healthcare Director on regulation 2600.190c, documentation shall be kept in accordance with 2600.65i.
-Beginning 5/30/25, the Healthcare Director or designee shall audit the med tech paperwork/files quarterly for accuracy.
-To ensure consistent adherence to Regulation 2600.190c, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/21/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. 5/19/25).

Proposed Overall Completion Date: 05/30/2025

Directed Completion Date: *05/30/2025*

Implemented - 07/28/2025)

225a - Assessment 15 Days

14. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #2's medical evaluation, dated /25, includes a diagnosis of Anxiety; however, this diagnosis is not indicated on resident #2's assessment, dated 13/25.

REPEAT VIOLATION: 12/26/2024

Plan of Correction ***Directed - 05/19/2025)***

-On 4/17/25, resident 2's assessment was updated to include the diagnosis of Anxiety by the Health Care Director.
-On 5/8/25, the Regional Health Care Director has educated the Healthcare Director, Assistant Healthcare Director

225a - Assessment 15 Days (continued)

and Wellness nurse on the importance of Regulation 2600.225.a, documentation shall be kept in accordance with 2600.65i.
-By 5/30/25, the Health Care Director or designee will audit current resident assessments to assure diagnoses on the Medical Evaluation are indicated on the assessment.
-Beginning 5/30/25, the Healthcare Director shall review newly created assessments in comparison to the medical evaluation prior to filing in resident's chart. (DIRECTED: The audits of newly-completed assessments shall be conducted weekly. [redacted] 5/19/25).
-To ensure consistent adherence to Regulation 2600.225a, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/21/25, documentation shall be kept, further ensuring our commitment to transparency and accountability. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. [redacted] 5/19/25).

Proposed Overall Completion Date: 05/30/2025

Directed Completion Date: *05/30/2025*

Implemented [redacted] - 07/28/2025)

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**: *07/13/2025*

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

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

Administrator

Name: [redacted]

Legal Entity

Name: *CA SENIOR MCCANDLESS OPERATOR LLC*

Address: [redacted]

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *224* **Waking Staff**: *168*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *05/02/2025*

Inspection Dates and Department Representative

05/02/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *211* **Residents Served**: *165*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *first floor - Reflections* **Capacity**: *35* **Residents Served**: *30*

Hospice

Current Residents: *23*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *164*

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

Have Mobility Need: *59* **Have Physical Disability**: *0*

Inspections / Reviews

05/02/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/28/2025*

05/29/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/27/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/04/2025*

06/03/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/27/2025*

[redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/30/2025*

07/28/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/27/2025*

[redacted] **Follow-Up Type:** *Exception*

42c - Treatment of Residents

1. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On 4/19/25 at approximately 10:30pm, direct care staff person A entered residents #1 and #2's shared bedroom to administer resident #1's evening medications. At this time, direct care staff person B was present in the shared bedroom and had just assisted with transferring resident #1 into [redacted] bed. Direct care staff person A asked direct care staff person B to transfer resident #1 back into [redacted] wheelchair so direct care staff person A could administer resident #1 [redacted] medications while resident #1 is sitting up. At that time, direct care staff persons A and B got into a loud verbal altercation in front of residents #1 and #2 about resident #1 having to be transferred out of bed for the medication administration. Direct care staff person B then left the shared bedroom and direct care staff person A completed the transfer of resident #1 and administered resident #1 [redacted] evening medications. Resident #1 became tearful while recalling the incident to an Agent of the Department and resident #2 indicated the incident made [redacted] angry and upset.

REPEAT VIOLATION: 12/26/2024

Plan of Correction ***Directed [redacted] - 06/03/2025)***

- On 5/2/2025 the Residence Director and HCD met with staff person B to review Legend Senior Living's policy regarding resident care and proper communication with residents and between staff. This meeting also included re-education on regulation 42c, regarding treating residents with dignity and respect, and what that looks like in practice. Documentation of this meeting was kept. Staff person A was put on suspension immediately and has since been [redacted] on [redacted] 025. Staff person A was terminated due to policy violation per human resources.
- By 6/3/2025 The Residence Director and/or designee shall educate all staff on resident rights, with additional attention on treating residents with dignity and respect. Documentation of this training shall be kept.
- Beginning on 6/1/25, the Residence Director and/or designee shall randomly interview 5 different residents per week for 4 weeks to determine whether any of their resident rights have been violated. Documentation of these interviews shall be kept. (DIRECTED: The resident interviews shall be conducted in private.[redacted] 6/3/25).
- Beginning in May of 2025 and for three months thereafter, the Administrator or designee shall attend the monthly resident council meeting, with their approval, to hear and address any concerns regarding resident rights.
-To ensure consistent adherence to Regulation 2600.42c, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 6/18/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.26b.

Proposed Overall Completion Date: 06/27/2025

Directed Completion Date: *06/18/2025*

Implemented [redacted] - 07/28/2025)

185a - Implement Storage Procedures

2. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #3 is currently prescribed, Bisacodyl 10mg suppository-Insert 1 suppository rectally every 4th day as needed if Milk of Magnesia is unsuccessful and no bowel movement by morning. However, this medication was not present in the home and available for administration.

Plan of Correction ***Directed [redacted] 06/03/2025)***

- The missing medication identified for resident #3 was ordered and delivered by the pharmacy on 4/19/2025. (These medications have since been discontinued due to nonuse on 5/8/2025.)
- By 6/3/2025, the Health Care Director and/or designee shall re-educate all staff who administer medication on the Community's process for re-ordering medications before it runs out and checking the cart after each shift to ensure all routine orders are available for administration for the next shift. Currently the community is on Cycle fill for all routine medications every 30 days. Documentation of this training shall be kept as per regulation guidelines.
- By 6/30/2025, Omnicare Pharmacy, Health Care Director, or designee shall complete a full EMAR to medication cart audit to ensure there is medication on site for all resident medication orders. Documentation of this audit shall be kept as per regulation guidelines.
-Beginning 6/1/2025, The Health Care Director, Assistant Health Care Director or designee shall complete an EMAR to Cart audit of 10 residents weekly for 4 weeks and then monthly for three months to ensure ongoing compliance with this regulation. Documentation of these audits shall be kept as per regulation guidelines.
- The Residence Director will review the weekly audits beginning 6/8/25 and then monthly during the Quality Management meeting, thereafter, and address as needed. The Next QMPI meeting is 6/18/2025.
- To ensure consistent adherence to Regulation 2600.185a, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on _6/18/2025_, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.26b.

Proposed Overall Completion Date: 06/27/2025

Directed Completion Date: *06/30/2025*

Implemented [redacted] - 07/28/2025)

187b - Date/Time of Medication Admin.

3. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

On 4/19/25, direct care staff person A administered the following medications to resident #1 at 10:27pm; however, the medication administration times for these medications were documented as administered at 8:00pm on resident #1's May 2025 medication administration record (MAR):

187b - Date/Time of Medication Admin. (continued)

- *The evening dose of Eliquis 2.5mg tablet-Take 1 tablet by mouth twice daily*
- *Loratadine 10mg tablet-Take 1 tablet by mouth every evening*
- *The evening dose of Magnesium Oxide 400mg tablet-Take 1 tablet my mouth 3 times daily*
- *The evening dose of Baclofen-5mg tablet-Take 1 tablet by mouth 3 times daily*
- *Relaxium Sleep SIG capsules-Take 2 capsules by mouth daily at bedtime*

Plan of Correction ***Directed [redacted] - 06/03/2025)***

-By 6/3/25, The Health Care Director and/or designee shall re-educate all staff who administer medication on the Community's process for recording the administration of medication at the time it was administered. Documentation of this training shall be kept as per regulation. Unable to address/counsel staff person A as [redacted] was[redacted] on 5/7/2025. Doctor was notified on 6/2/25 of late administration of medication of resident #1's pm medications.

- By 6/10/2025, a random EMAR audit of 10 residents shall be completed by the Health Care Director and/or designee to check for discrepancies between the actual and documented times of administration of medications, for all medication carts, on all three shifts. (DIRECTED: Beginning on 6/10/25: The audits of 10 resident MAR's shall be conducted weekly for 4 weeks, then monthly thereafter.[redacted] 6/3/25).
- Beginning 6/1/25, The Healthcare Director or designee shall complete a random medication pass observation weekly, for 4 weeks, to observe that medications are administered timely, and then monthly ending on 9/1/25 to monitor for ongoing compliance. Documentation of these observations shall be kept as per regulation guidelines.
- The Residence Director will review the weekly audits beginning 6/8/25 and then monthly during the Quality Management meeting, thereafter, and address as needed.
- To ensure consistent adherence to Regulation 2600.187b, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 6/18/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.26b.

Proposed Overall Completion Date: 06/27/2025

Directed Completion Date: *06/18/2025*

Implemented [redacted] - 07/28/2025)