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

June 10, 2025

[redacted], LEGAL ENTITY
CARE HSL HERITAGE HILL OPCO LLC
[redacted]

RE: HERITAGE HILL SENIOR COMMUNITY
800 SIXTH STREET
WEATHERLY, PA, 18255
LICENSE/COC#: 22512

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/06/2025 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 HILL SENIOR COMMUNITY* **License #**: *22512* **License Expiration**: *04/18/2026*

Address: *800 SIXTH STREET, WEATHERLY, PA 18255*

County: *CARBON* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *CARE HSL HERITAGE HILL OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/05/2000* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *169.25* **Total Daily Staff**: *278.25* **Waking Staff**: *209*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *05/06/2025*

Inspection Dates and Department Representative

05/06/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *143* **Residents Served**: *82*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *30* **Residents Served**: *27*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *109*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *27*

Have Physical Disability: *0*

Inspections / Reviews

05/06/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/29/2025*

Inspections / Reviews *(continued)*

06/03/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/09/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/10/2025*

06/10/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/09/2025*

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

20b3 - Written Receipts

1. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
3. The home shall obtain a written receipt from the resident for cash disbursements at the time of disbursement.

Description of Violation

A cash disbursement of $20.00 was made to resident 1. However, the home did not obtain the resident signature for the receipt of the disbursement.

A cash disbursement of $10.00 was made to resident 2. However, the home did not obtain the resident signature for the receipt of the disbursement.

Plan of Correction ***Accept (- 06/03/2025)***

Immediate Corrective Actions: On 5/16/2025 a physical log of residents with existing sums of money in the community safe was created by the Business Office Director (BOD) with areas for resident signatures for disbursements made. This will be overseen by the Business Office Director (BOD) to ensure it is updated as needed.
Additional Corrective Actions: The community will discontinue the practice of offering residents the option to keep cash in the community safe. The resident handbook and home rules will be updated to reflect the same, effective July 15th, 2025. Existing funds will be returned to residents or their POA no later than July 15th, 2025. A 30-day notice will be provided to all residents and their POA/designated person. All Additional Corrective Actions will be overseen by the Executive Director or Business Office Director.
Ongoing Quality Assurance Actions: The Resident Care Director (RCD) will ensure that each resident's RASP will show who will assist each resident with managing funds as needed. If assistance is required, appropriate referrals will be made. Ongoing compliance will be reviewed at Quarterly QA meetings, beginning in July 2025.

Proposed Overall Completion Date: 07/15/2025

Licensee's Proposed Overall Completion Date: *06/15/2025*

Implemented (- 06/10/2025)

51 - Criminal Background Check

2. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff member A did not have a Criminal background check completed upon hiring date of

Plan of Correction ***Accept (- 06/03/2025)***

Immediate Corrective Actions: A background check was completed at the time of original hire of Staff Member A. Due to the time lapse, a new background check for rehire was requested from The Pennsylvania State Police on 5/21/2025 by the Business Office Director (BOD) and will remain as part of the employee's permanent file.

51 - Criminal Background Check (continued)

Additional Corrective Actions: The management team; including Business Office Director, Marketing Director, Memory Care Director, Maintenance Director, Environmental Services Director, Food Service Director, Resident Life Director, and Resident Care Director were retrained on 5/19/2025 on 2600.51 – Criminal Background Checks by the Executive Director (ED). All hires and rehires, regardless of the time elapsed since prior Criminal Background Check, will have a new Criminal Background Check conducted. This will be overseen by the Business Office Director. All staff records will be audited to ensure timely Criminal Background Checks are in place for all current staff. This will be completed by the Business Office Director (BOD) by June 15th, 2025.
Ongoing Quality Assurance Actions: A sample of staff records will be reviewed each month by the Business Office Director. Findings and trends will be reviewed at Quarterly QA meetings, beginning in July 2025.

Licensee's Proposed Overall Completion Date: *06/15/2025*

Implemented ([redacted] - 06/10/2025)

100a - Exterior - Free of Hazards

3. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

At 9:45 a.m., a drainpipe that is in the middle of a walkway in the Secured Dementia Unit courtyard was raised approximately ¾ of an inch, causing a tripping hazard.

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

Immediate Corrective Actions: On May 20, 2025 the Maintenance Director placed and smoothed concrete around the elevated drain, creating an even surface free of tripping hazards.
Additional Corrective Actions: The monitoring of tripping hazards in walkways will be added to the Daily Maintenance Walkthrough Checklist, beginning on 5/26/2025, which is completed by the Maintenance Director or Maintenance Assistant daily. This checklist is to be submitted to the Executive Director monthly. The Safety Committee reviewed this deficiency on 5/15/2025.
Ongoing Quality Assurance Actions: Findings and trends will be reviewed at Quarterly QA meetings, beginning in July 2025.

Licensee's Proposed Overall Completion Date: *05/29/2025*

Implemented ([redacted] - 06/10/2025)

121a - Unobstructed Egress

4. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

At 9:30 a.m., the laundry room exit door was locked and required a key to open, creating an obstructed egress.

121a - Unobstructed Egress *(continued)*

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

Immediate Corrective Actions: On 5/7/2025, a key was placed next to the laundry room exit door by the Maintenance Director (MD) allowing for unobstructed access, and staff were alerted to its location. The interior laundry room door will be closed when employees are not present, as this area is not a throughway for residents or visitors, nor is it an area used by anyone other than staff. The interior door automatically locks when closed, so that only staff are able to access this area.
Additional Corrective Actions: Monitoring for unobstructed egress will be added to the Daily Maintenance Walkthrough Checklist, beginning on 5/26/2025, which is completed by the Maintenance Director or Maintenance Assistant daily. This checklist is to be submitted to the Executive Director monthly.
Ongoing Quality Assurance Actions: Findings and trends will be reviewed at Quarterly QA meetings, beginning in July 2025.

Licensee's Proposed Overall Completion Date: *05/29/2025*

Implemented ([redacted] - 06/10/2025)

131f - Fire Extinguisher Inspection

5. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The exterior fire extinguisher located near the designated smoking area had a tag that was not dated to indicate the year and month of last inspection and expiration date.

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

Immediate Corrective Actions: On 5/7/2025, the Maintenance Director placed the date of inspection on the tag of the fire extinguisher in the designated smoking area. The date of inspection was 3/10/2025, and the smoking area fire extinguisher is listed as having been inspected on this date as noted on the Work Acknowledgement from the contractor.
Additional Corrective Actions: Monitoring for properly marked fire extinguisher inspection tags will be added to the Daily Maintenance Walkthrough Checklist, beginning on 5/26/2025, which is completed by the Maintenance Director or Maintenance Assistant daily. This checklist is to be submitted to the Executive Director monthly. This Safety Committee reviewed this deficiency on 5/15/2025.
Ongoing Quality Assurance Actions: Findings and trends will be reviewed at Quarterly QA meetings, beginning July 2025.

Licensee's Proposed Overall Completion Date: *05/29/2025*

Implemented ([redacted] - 06/10/2025)

181d -Storing Medication

6. Requirements

2600.

181d -Storing Medication *(continued)*

181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident #3 self-administers medications and stores medications in their room. At 3:30 p.m. the resident's bedroom door was unlocked and unattended; a bottle of Nystatin Powder was stored on the resident's bathroom sink countertop.

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

Immediate Corrective Actions: Nystatin powder was immediately removed from the bathroom counter of Resident #3 and stored in the locked Medication Cart, by the Wellness Nurse. It was discussed with Resident #3 and Resident #3's POA that the community encouraged the discontinuation of self-administration of this medication at bedside. Resident #3 and family are in agreement. A RASP addendum was completed on 5/7/2025, which notes the discontinuation of self-administration of medication.
Additional Corrective Actions: A Resident Acknowledgement of Medication Self-Administration Responsibilities form was created on 5/21/2025, which includes the outline of requirements related to locking the resident's room when the resident is not present, preventing any self-administered medications from being accessed by another person. All residents who currently self-administer medication, and future residents with self-administration orders will be required to sign this form. Any existing residents with self-administration orders will be required to sign this form no later than May 30th, 2025. Future residents will be required to sign the form at the time of order of self-administration of medication. This will be overseen by Resident Care Director (RCD) and Executive Director (ED).
Ongoing Quality Assurance Actions: A sample of resident rooms with self-administration of medication orders will be audited monthly to verify the security of meds. Findings and trends will be reviewed at Quarterly QA meetings, beginning in July 2025.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented ([redacted] - 06/10/2025)

185a - Implement Storage Procedures

7. 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 5/6/25, at 7:20 a.m., resident #4, Accu-Chek reading of 170 was not documented on the Medication Administration record..

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

Immediate Corrective Actions: On 5/6/2025, during pharmacy provider change occurring at the time of inspection, it was discovered that an area did not exist on the new MAR system to record blood glucose readings. The Wellness Nurse corrected the MAR immediately upon discovery, which was after the first blood glucose check of the day. Recordings are also noted on the Med Tech Shift Change Responsibility sheet, which is utilized at the end of each shift and checked against the MAR.
Additional Corrective Actions: Medication Technicians will continue to utilize the Med Tech Shift Change Responsibility sheet, verifying the blood glucose monitor reading against the MAR. Beginning 5/7/2025, they will submit the completed Shift Change Responsibility forms to the Resident Care Director daily for review and oversight.
Ongoing Corrective Actions: Findings and trends will be reviewed at Quarterly QA meetings, beginning in July

185a - Implement Storage Procedures (continued)

2025. Concerns related to the MAR system will be relayed to the pharmacy provider to be addressed, with overall oversight for compliance from the Executive Director and Resident Care Director.

Licensee's Proposed Overall Completion Date: *05/27/2025*

Implemented (- 06/10/2025)

231c - Preadmission Screening

8. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident # 5 was admitted to the Secure Dementia Care Unit (SDCU) on However, Resident # 5 written cognitive preadmission screening was not completed.

Plan of Correction ***Accept (- 06/03/2025)***

Immediate Corrective Actions: This deficiency could not be immediately corrected because the affected resident was . Prior to the return of Resident #5, a new written cognition screening will be obtained by Resident Care Director (RCD)
Additional Corrective Actions: On May 22, 2025 Director of Quality Assurance will retrain the Executive Director, Memory Care Director, and Resident Care Director on the requirement of preadmission cognitive screenings on all residents admitted to the Memory Care unit. An audit will be conducted of all current Memory Care residents to ensure complete Preadmission Cognitive Screenings are present for each resident.
Ongoing Corrective Actions: A sample of 10 residents per quarter will be reviewed to ensure continued compliance. Findings and trends will be reviewed at Quarterly QA Meetings, beginning in July 2025.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented (- 06/10/2025)