

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

September 25, 2025

[REDACTED] OWNER
HERITAGE GROVE AT INDIANA LLC
[REDACTED]

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

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/06/2025, 05/07/2025, 05/13/2025 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: 02/13/2026
 Address: 1703 WARREN ROAD, INDIANA, PA 15701
 County: INDIANA Region: WESTERN

Administrator

Name: Kathy Yahner Phone: 814-322-8900 Email: key1218@aol.com

Legal Entity

Name: HERITAGE GROVE AT INDIANA LLC
 Address: 70 BARRET ROAD, LAWRENCE, NY, 11559
 Phone: 3477210782 Email: AHRONSTARK35@GMAIL.COM

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: 61 Waking Staff: 46

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal, Complaint Exit Conference Date: 06/24/2025

Inspection Dates and Department Representative

05/06/2025 - On-Site: [REDACTED]
 05/07/2025 - On-Site: [REDACTED]
 05/13/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 80 Residents Served: 38
 Secured Dementia Care Unit
 In Home: Yes Area: SDCU Capacity: 40 Residents Served: 18
 Hospice
 Current Residents: 3
 Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 38
 Diagnosed with Mental Illness: 1 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 23 Have Physical Disability: 0

Inspections / Reviews

05/06/2025 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 07/25/2025

Inspections / Reviews *(continued)*

07/31/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/24/2025

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 08/05/2025

09/15/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/24/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 10/01/2025

09/25/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/24/2025

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

Resident #1 was prescribed the following medications: Jardiance 10 mg - 1 tablet daily, Entresto 24-26 mg - 1 tablet twice daily, and

Spironolactone 25 mg - 1 tablet daily. These medications were not administered from 5/7/25 to 5/13/25; however, these medication errors were not reported to the Department.

Repeat violation: 10/16/24, 1/3/25

Plan of Correction

Accept ([redacted]) - 09/12/2025)

The labels had been corrected while the Licensing Representatives were on-site The Res Care Coordinator or designee will audit our Point Click Care program weekly for 60 days to ensure compliance is being met. An immediate verbal training had been completed with our Res Care Coordinator, an additional training on regulation 16c will be completed by RCC or designee on identifying and communicating missed medications and the importance of timely reporting of the incident . The training on missed medication communication and regulation 16c will be completed by Aug 30/25. All incidents with regards to regulation 16c will be discussed at our QI meeting

Licensee's Proposed Overall Completion Date: 09/30/2025

Implemented ([redacted]) - 09/25/2025)

18 - Compliance With Laws

2. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted on 6-23-16, requires carbon monoxide alarms to be installed in close proximity to, but not less than 15 feet from, any fossil-fuel burning device or appliance. No carbon monoxide detectors were present near the gas dryer in the laundry room as required by The Care Facility Carbon Monoxide Alarms Standards Act.

Plan of Correction

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

The CO2 device was immediately installed while Licensing Representatives were onsite . The Maint Director or designee will check the CO2 devices to ensure they remain in place and functioning properly once a month for 3 months and will continue to audit and check quarterly thereafter.

Licensee's Proposed Overall Completion Date: 10/15/2025

Implemented ([redacted]) - 09/25/2025)

65f - Training Topics

3. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

- 3. Care for residents with dementia and cognitive impairments.
- 4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
- 5. Personal care service needs of the resident.
- 6. Safe management techniques.

Description of Violation

Direct care staff member A, hired on [REDACTED], did not complete training in the following topics in training year January to December 2024:

- *Care for residents with dementia and cognitive impairments.
- *Infection control and general principles of cleanliness and hygiene
- *Personal care service needs of the resident.
- *Safe management techniques

Plan of Correction

Accept ([REDACTED] - 09/15/2025)

The ED or designee had developed and executed the monthly training plan while Licensing Reps were on-site to ensure that all topics, as well as training hours are being met. Staff members A and B had required missing training on Aug 7. The ED or designee will audit all employee files monthly for training to ensure compliance for the next 3 months and ongoing thereafter quarterly. A training will be provided by RCC or designee for all staff members reviewing regulation 65f and will be completed by Aug 30

Licensee's Proposed Overall Completion Date: 10/31/2025

Implemented ([REDACTED] - 09/25/2025)

65g - Annual Training Content

4. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

- 3. Resident rights.
- 4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
- 5. Falls and accident prevention.

Description of Violation

Direct care staff member A hired [REDACTED] and ancillary staff member B, hired [REDACTED] did not complete training in the following topics in training year January to December 2025:

- *Resident rights.
- *The Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102).
- *Falls and accident prevention.

Plan of Correction

Accept ([REDACTED] - 09/15/2025)

Required training were completed for employee Employee A and B Aug 7 The RCC, ED, or designee will complete training for all staff members on DHS required topics, regulation 65 g with a completion date of Sept 30/25. An audit will be completed for each employee, 4 employees a week until completed and then monthly for 3 months to ensure compliance is maintained.

65g - Annual Training Content (continued)

Licensee's Proposed Overall Completion Date: 09/30/2025

Implemented () - 09/25/2025

85a - Sanitary Conditions

5. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 5/6/25 a used adhesive bandage was found in the drain of a shower in the Secure Dementia Care Unit (SDCU) shower room.

On 5/6/25 there were five unlabeled bars of used soap in the SDCU shower room.

Plan of Correction

Accept () - 07/31/2025

The bandage was removed immediately while Licensing Representatives were onsite. The bars of soap were removed and replaced with Labeled body wash soap bottles The ED or designee will complete a training on sanitation and labeling of individuals items and regulation 85a. The training will be completed by Sep 30/25. Weekly audits will be completed by RCC or designee weekly for 1 month and then monthly for 3 months to ensure compliance

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

Implemented () - 09/25/2025

132b - Safety Inspection/Fire Drill

6. Requirements

2600.

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

Description of Violation

The home's most recent fire safety inspection and supervised fire drill conducted by a fire safety expert was completed on 2/29/24.

Plan of Correction

Accept () - 07/31/2025

The Fire Safety inspection was completed on 5/21/25 and will be scheduled annually by the fire safety expert company themselves on or before this date for 2026 . A written reminder will be placed into the fire drill log. A training on regulation 132b will be completed by Sept 30/25 with Maint Director or designee to ensure compliance. Monthly audits will be completed for 3 month by the ED or designee to ensure the inspection is present and up to date

Licensee's Proposed Overall Completion Date: 09/30/2025

Implemented () - 09/25/2025

132c - Fire Drill Records

7. Requirements

2600.

132c - Fire Drill Records *(continued)*

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

On the following dates and times, the fire drill log records the incorrect number of residents in the home at the time the fire drill was conducted:

<i>Date and Time</i>	<i>Number of residents in the home</i>	<i>Number of residents recorded on the log</i>
2/25/24 2:45 PM	31	33
10/31/24 11:35 PM	30	36
1/31/25 1:10 PM	31	33
2/27/25 2:35 PM	37	39

Plan of Correction

Accept ([REDACTED]) - 09/15/2025)

The Licensing Representatives had provided technical support while onsite for the Maint Director and completion of fire drills, times, dates, routes. The fire safety expert had completed a training on June 4th as well as a follow up training completed Aug 13,2025 by the ED for compliance procedures for DHS 32c regulations. The ED or designee will complete monthly audits for the next 3 months to ensure compliance.

Licensee's Proposed Overall Completion Date: 10/31/2025

Implemented ([REDACTED]) - 09/25/2025)

132d - Evacuation

8. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The fire drill records for the following fire drills indicate evacuation times that exceeded 2 minutes, 30 seconds; however, there is no documentation from a fire safety expert since 2/29/24 indicating a maximum safe evacuation time that exceeds 2 minutes, 30 seconds.

<i>Date and Time</i>	<i>Evacuation Time</i>
3/29/24 12:45 PM	4 Min. 56 Sec.
4/30/24 2:25 PM	4 Min. 38 Sec.
5/29/24 5:10 AM	9 Min. 11 Sec.
6/28/24 12:45 PM	4 Min. 56 Sec.
7/25/24 2:45 PM	4 Min. 41 Sec.
8/28/24 12:30 PM	5 Min. 23 Sec.
9/19/24 5:00 AM	4 Min. 51 Sec.

132d - Evacuation (continued)

10/31/24	1:35 PM	4 Min. 16 Sec.
11/29/24	3:30 PM	4 Min. 45 Sec.
12/27/24	10:35 AM	4 Min. 27 Sec.
1/31/25	1:10 PM	3 Min. 51 Sec.
2/27/25	2:35 PM	4 Min. 07 Sec.
3/31/25	1:10 PM	4 Min. 11 Sec.
4/11/25	11:30 PM	5 Min. 41 Sec.

On 9/19/24 at 5:00 AM, there were 34 residents present in the home; however, only 33 residents were evacuated during the fire drill held at that time.

Plan of Correction

Accept () - 07/31/2025

The Fire Safety Expert had completed the onsite fire drill on 5/21/25 and had established a safe evacuation time of 6 mins and 30 secs. The ED or designee will complete a training by Sept 30/25 on regulation 132d. A monthly audit will be completed by the Maint Director or designee monthly for 3 months to ensure compliance

Licensee's Proposed Overall Completion Date: 10/31/2025

Implemented () - 09/25/2025

132e - Fire Drill Sleeping Hours

9. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The home held a sleeping hour fire drill on 9/19/24 at 5:00 AM; however, the home did not conduct another sleeping hour fire drill until 4/11/25 at 11:30 PM.

Plan of Correction

Accept () - 09/15/2025

A sleeping hour fire drill is schedule for Sept 2025 previous sleeping fire drill was completed in April 2025. A training will be completed by the Maint Director or designee on 132e regulation and was completed Aug 13, 2025. An audit will be completed by the ED or designee monthly for 6 months to ensure compliance. A written reminder will be placed into the fire drill log

Licensee's Proposed Overall Completion Date: 10/31/2025

Implemented () - 09/25/2025

141b1 - Annual Medical Evaluation

10. Requirements

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

Description of Violation

Resident #2's annual documentation of medical evaluation (DME) dated () did not document the resident's ability to self-administer medication. This section was blank.

Resident #3 was admitted to the home on () however, () has not had a medical evaluation within the past

141b1 - Annual Medical Evaluation (continued)

year. There were no DMEs in the resident's record.

Repeat Violation: 5/7/24

Plan of Correction

Accept (█) - 09/15/2025)

Completed DME were located for res #2 updated self-administration portion the day of inspection, but upon review the MD signature piece was also missing some information sending 9/8/2025 for medical professional information completion and res #3 completed on 5/6/2025 . A training will be completed with the RCC or designee on regulation 141b1 and will be initiated by Aug 31,2025. An audit of 4 residents a week will be completed weekly for 10 weeks to ensure completion and will continue monthly for 3 months

Licensee's Proposed Overall Completion Date: 10/31/2025

Implemented (█) - 09/25/2025)

184a - Resident's Meds Labeled

11. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

- 4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #2 was prescribed Ondansetron 4 mg – 1 tablet three times a day as needed for nausea and vomiting. However, the pharmacy label on the medication indicated █ was prescribed Ondansetron 4 mg – 1 tablet every 6 hours as needed.

Plan of Correction

Accept (█) - 09/15/2025)

A corrected label was placed onto the medication while the Licensing Representatives were on-site. A medication Cart audit will be completed by the RCC or designee for each resident and will cross check labels with the medication orders the audits will start by Aug. 31 st . The audit will be completed by Sept 30. A training will be provided to all med techs by the RCC or designee reviewing regulation 184a and will be completed by Aug 31,2025

Licensee's Proposed Overall Completion Date: 09/30/2025

Implemented (█) - 09/25/2025)

184b - Labeling OTC/CAM

12. Requirements

2600.

184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

A bottle of Refresh Eye Drops that belonged to resident #2 was not labeled with the resident's name.

Plan of Correction

Accept (█) - 09/15/2025)

The eye drops were labeled while Licensing Representatives were on-site. A training will be completed with all med techs on regulation 184b by the RCC or designee by Aug 31st . A Cart audit will be completed, starting by Aug 31 with 4 res per week for 4 weeks and then monthly thereafter for an additional 3 months completed by the RCC or designee.

184b - Labeling OTC/CAM (continued)

Licensee's Proposed Overall Completion Date: 10/31/2025

Implemented () - 09/25/2025

185a - Implement Storage Procedures

13. 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

The home's medication policy indicates that "All controlled substances will have a 2-person count after each shift to ensure an accurate count of all controlled substances; however, according to staff interviews the home does not do these counts.

Repeat Violation: 5/7/24

Plan of Correction

Accept () - 09/15/2025

The policy was implemented immediately the same day while the Licensing Representatives were on-site. An additional training will be completed with all med techs by the RCC or designee by Aug 31st on regulation 185a. An audit will be started by Aug 31st and will be completed by the RCC or designee reviewing the Narcotic sign off book weekly for 4 weeks and then monthly for 3 months

Licensee's Proposed Overall Completion Date: 10/31/2025

Implemented () - 09/25/2025

187d - Follow Prescriber's Orders

14. Requirements

2600.

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

Description of Violation

Resident #1 was prescribed the following medications:

Jardiance 10 mg - 1 tablet daily

Entresto 24-26 mg - 1 tablet twice daily

Spironolactone 25 mg - 1 tablet daily

These medications were not administered from 5/7/25 to 5/13/25 because they were not available in the home.

Plan of Correction

Accept () - 09/15/2025

The medications Jardiance 10 mg, 1 tab daily, Entresto 24-26 mg 1 tab 2x daily, and Spironolactone 25 mg 1 tab daily were ordered using the scripts from the VA from the local pharmacy the day of inspection and will continue to be if they do not arrive and are not on-site to be administered per directions. The VA home had been notified by our Res Care Director of the regulation and compliance expectations. A training will be provided by the RCC or designee on regulation 187d starting by Aug 31st. A chart audit will be completed by the RCC or designee starting by Aug 31, 4 residents weekly until completed and then monthly for 3 months to ensure continued compliance

187d - Follow Prescriber's Orders (continued)

Licensee's Proposed Overall Completion Date: 10/31/2025

Implemented () - 09/25/2025

224a - Preadmission Screen Form

15. Requirements

2600.

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

Description of Violation

A preadmission screening was not completed for resident #1, who was admitted to the home on [redacted]

Resident #5 was admitted to the home on [redacted]; however, a preadmission screening was not completed for [redacted] until [redacted]

Plan of Correction

Accept () - 09/15/2025

A verbal training for regulation 224a had been completed with the RCC by the ED while the DHS were on-site. Additional employee training will be provided by the RCC or designee on regulation 224a and will be started by Aug 31st. An audit will be completed by the RCC or designee of all resident charts starting on Aug 31st, the audit will consist of 4 residents weekly until completed anticipated 60 days full completion and then monthly for 3 months ensuring continued compliance

Licensee's Proposed Overall Completion Date: 10/15/2025

Implemented () - 09/25/2025

225a - Assessment 15 Days

16. 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 #1's initial assessment was undated. This section was blank; therefore, the timeliness of this assessment cannot be determined.

Plan of Correction

Accept () - 09/15/2025

Res #1 assessment was updated, dated, and signed by the Res Care Coordinator to reflect the date of completion on [redacted] original was completed on [redacted]. A training will be provided by the RCC or designee on regulation 225a and will be started by Aug 31st. An audit will be completed by the RCC or designee of all the residents, 4 res to be completed weekly until completed starting on Aug 31st approx 60 days for completion. The audits will continue to be completed monthly for 3 months to ensure continued compliance

225a - Assessment 15 Days (continued)

Licensee's Proposed Overall Completion Date: 10/31/2025

Implemented () - 09/25/2025

231c - Preadmission Screening

17. 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

A cognitive preadmission screening was not completed for resident #1, who was admitted to the secure dementia care unit on ()

Plan of Correction

Accept () - 09/15/2025

A training on regulation 231c will be provided by the RCC or designee and will be started by Aug 31st completed by Sept 30. An audit will be done by the RCC or designee starting on Aug 31 of 4 resident a week until completed which would be approx 60 days, the audits will then continue monthly for 3 months to ensure consistent compliance

Licensee's Proposed Overall Completion Date: 09/30/2025

Implemented () - 09/25/2025

234a - Admission Support Plan

18. Requirements

2600.

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

Description of Violation

Resident #1's initial support plan was undated. This section was blank; therefore, the timeliness of this support plan cannot be determined.

Plan of Correction

Accept () - 09/15/2025

Res #1 SP was updated, dated, and signed to reflect the correct completion date. A training will be provided by the RCC or designee on regulation 234a and will be started by Aug 31st completed by Sept 30. An audit will be completed by the RCC or designee starting on Aug 31, 4 resident per week until completed approx 60 days and then monthly for 3 months to ensure consistent compliance

Licensee's Proposed Overall Completion Date: 10/15/2025

Implemented () - 09/25/2025