



Pennsylvania Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: AUGUST 14, 2025

[REDACTED], Owner
Heartful Hands LLC

RE: Heartful Hands LLC
514 Mitchell Avenue
Clairton, Pennsylvania 15025
License: 45370

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection on March 13, 2025, March 20, 2025, March 31, 2025, April 21, 2025, April 23, 2025, June 17, 2025 and July 17, 2025, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 45370) dated November 29, 2024 – November 29, 2025, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2); (3); (4); (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and August 14, 2025 to February 14, 2026.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[REDACTED] Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, PA 17105-2675
[REDACTED]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,



Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

[REDACTED]

Facility Information

Name: HEARTFUL HANDS LLC License #: 45370 License Expiration: 11/29/2025
 Address: 514 MITCHELL AVENUE, CLAIRTON, CLARITON, PA 15025
 County: ALLEGHENY Region: WESTERN

Administrator

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

Legal Entity

Name: HEARTFUL HANDS LLC
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-1 Date: 06/14/2010 Issued By: City of Clairton

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 27 Waking Staff: 20

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
 Reason: Complaint Exit Conference Date: 03/31/2025

Inspection Dates and Department Representative

03/13/2025 - On-Site: [REDACTED]
 03/20/2025 - Off-Site: [REDACTED]
 03/31/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 36 Residents Served: 26
 Secured Dementia Care Unit
 In Home: No Area: Capacity: Residents Served:
 Hospice
 Current Residents: 0
 Number of Residents Who:
 Receive Supplemental Security Income: 23 Are 60 Years of Age or Older: 26
 Diagnosed with Mental Illness: 26 Diagnosed with Intellectual Disability: 3
 Have Mobility Need: 1 Have Physical Disability: 0

Inspections / Reviews

03/13/2025 - Partial
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 04/12/2025

Inspections / Reviews (*continued*)

04/14/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/13/2025

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 04/18/2025

04/21/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/13/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 04/26/2025

07/23/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/13/2025

Reviewer: [REDACTED]

Follow-Up Type:

85a - Sanitary Conditions

1. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 3/13/25, there was a brownish, sticky substance approximately 1/4" deep on top of an extra-large plastic container to the right of the dining room door leading to the side porch. There was also a residue of the brownish sticky substance in an outline of the bottom of the container on the dining room floor. Additionally, there was a power strip, and several extension cords covered in grime and a layer of dust to the right of this container.

Plan of Correction

Accept (█ - 04/21/2025)

Heartful Hands has disposed of the plastic container to the right of the dining room door and cleaned the floor where the sticky substance was outlined.

The Power strips and extension cords were replaced, please see the attached receipt listed as attachment #1.

The cigarette butts have been removed from the property, and no smoking signs have been purchased and hung in the areas where the cigarette butts were found, please see attachments #2, #3, and #4 showing the receipt of purchase as well as pictures of the no smoking signs.

Direct Caregivers will monitor the outside side porch and back daily during the 3pm-11pm shift to ensure that no one is smoking in non smoking areas

Licensee's Proposed Overall Completion Date: 04/18/2025

Implemented (█ - 07/23/2025)

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

On 3/13/25, the following was observed:

The latch did not catch on resident #1's bedroom door and could easily be pushed open.

A buildup of dirt and grime on the linoleum floors and baseboards throughout the home, including:

- Inside and outside of bathroom #3 and the hall leading from the bathroom to the dining room*
- Black shoe prints on the floor leading to and from the inside of bedroom 14 into bathroom #7*
- Dirt, black grime and debris on the dining room floor and threshold leading to the side porch*
- Dirt, black grime and a pungent, foul odor under the floor mat in front of the dining room door leading to the side porch*

A build-up of dirt and black grime around the bottom of the metal filing cabinet, and a dried substance splattered in multiple areas on the right side of the metal filing cabinet to the left of resident #1's bed.

88a - Surfaces (continued)

Plan of Correction

Accept (█) - 04/21/2025)

Heartful Hands has repaired the door latch on resident #1's bedroom door.

Regarding the linoleum floors: The owner operator will complete the remodel in the dining room and bathroom. We plan to complete the work between June 5th and 15th to ensure we can have an outdoor event for flooring installation. Please see the quotes for the remodel listed as attachment #5.

Heartful Hands has replaced the floor mat in the front of the dining room door leading to the side porch. Please see attachment #6 to show receipt of the floor mat purchase.

The metal file cabinets in resident rooms are currently being replaced with new dressers, please see the attachment listed as attachment #7.

Floor areas were cleaned; Employees will sign off on sign off sheet on 11pm-7am shift that they have cleaned dining room, bathroom, and kitchen floors. Floors will be monitored by night shift 11pm-7am staff,

Licensee's Proposed Overall Completion Date: 04/25/2025

Implemented (█) - 7/23/2025

95 - Furniture and Equipment

3. Requirements

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 3/13/25, the bottom drawer of the metal filing cabinet to the left of resident #1's bed could not be opened and was approximately 3/4 of the bottom was rusted. This filing cabinet is used for resident to store personal belongings, including clothing,

Plan of Correction

Accept (█) - 04/21/2025)

The metal file cabinets in resident rooms are currently being replaced with new dressers, please see the attachment listed as attachment #7.

7am-3pm Direct Care staff will monitor bedroom furniture twice a week during room cleanings

Licensee's Proposed Overall Completion Date: 04/18/2025

Implemented (█) - 7/23/2025)

141b1 - Annual Medical Evaluation

4. Requirements

2600.

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

Description of Violation

Resident #2's last medical evaluation was completed on █

Resident #3's last medical evaluation was completed on █

141b1 - Annual Medical Evaluation (continued)

Plan of Correction

Accept (█ - 04/21/2025)

Medical Evaluations for resident #2 and resident #3 are currently being updated along with all other residents out of compliance and will be completed by May 30,2025. Residents were seen by the doctor January 5, 2025, excel tracking system will be used to ensure that everyone stays up to date.

Licensee's Proposed Overall Completion Date: 04/18/2025

Not Implemented (█ - 7/23/2025)

225c - Additional Assessment

5. Requirements

2600.

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

- 1. Annually.

Description of Violation

The most recent assessment for resident #2 was completed on █

The most recent assessment for resident #3 was completed on █

Plan of Correction

Directed (█ - 04/21/2025)

Assessments (Resident Support Plans) for resident #2 and resident #3 are currently being updated along with all other residents out of compliance and will be completed by May 31,2025. Administrator will use a tracker in excel to track when each support plan is due. Administrator will make sure support plan is up to date with tracking system.

Within 5 days of receipt of the plan of correction - The administrator will ensure new assessments are is completed for residents #2 and #3. - █ 4/21/25

Within 15 days of receipt of the plan of correction - Assessments for all residents will be reviewed to ensure each resident has a current, accurate assessment completed. - █ 4/21/25

Directed Completion Date: 04/26/2025

Not Implemented (█ - 7/23/2025)

227i - Support Plan Accessible

6. Requirements

2600.

227.i. The support plan shall be accessible by direct care staff persons at all times.

Description of Violation

On 3/13/25, resident support plans were inaccessible to direct care staff. Also, according to staff person A, the administrator, resident support plans have not been updated.

Plan of Correction

Directed (█ - 04/21/2025)

Resident Support plans shall be updated by May 31,2025, as stated in POC #5. Support plans are currently available immediately in Med Room, Med Techs know where support plans are. Med Techs will monitor to make sure that support pans are available.

Within 5 days of receipt of the plan of correction - The administrator or a designee with monitor the support plans to ensure they are always available to direct care staff. - █ 4/21/25

227i - Support Plan Accessible (continued)

Within 21 days of receipt of the plan of correction - The administrator will review all support plans to ensure a current , accurate plan is in each resident's record. - [REDACTED] 4/21/25

Directed Completion Date: 04/18/2025

Not Implemented ([REDACTED] - 7/23/2025)

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

Facility Information

Name: *HEARTFUL HANDS LLC* License #: *45370* License Expiration: *11/29/2025*
Address: *514 MITCHELL AVENUE, CLAIRTON, CLARITON, PA 15025*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *HEARTFUL HANDS LLC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]@gmail.com

Certificate(s) of Occupancy

Type: *I-1* Date: *06/14/2010* Issued By: *City of Clairton*

Staffing Hours

Resident Support Staff: *27* Total Daily Staff: *55* Waking Staff: *41*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal* Exit Conference Date: *04/23/2025*

Inspection Dates and Department Representative

04/21/2025 - On-Site: [REDACTED]
04/23/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *36* Residents Served: *27*

Secured Dementia Care Unit

In Home: *No* Area: Capacity: Residents Served:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *27* Are 60 Years of Age or Older: *19*
Diagnosed with Mental Illness: *27* Diagnosed with Intellectual Disability: *5*
Have Mobility Need: *1* Have Physical Disability: *0*

Inspections / Reviews

04/21/2025 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *05/18/2025*

06/17/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/11/2025

Reviewer: [REDACTED]le

Follow-Up Type: POC Submission

Follow-Up Date: 06/22/2025

06/26/2025 - POC Submission

[REDACTED]

Date Submitted: 07/11/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 07/11/2025

07/23/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 07/11/2025

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

3c - Post Current License

1. Requirements

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 4/21/25 at 10:22 a.m., the most recent licensing inspection summaries, dated 7/8/23, 10/20/23 and 8/20/24, were not posted in a conspicuous and public place in the home.

Plan of Correction

Directed (█ - 06/23/2025)

All inspection reports will be posted on the board in the bulletin board in the main hallway placed downstairs in the living room of the building with the licensing summaries inside. The binder will be in the corner of the living room which is a public place where it can be accessed easily.

DIRECTED:

Within 24 hours of receipt of the plan of correction and at least weekly thereafter - The administrator will monitor all postings in the home, including licensing inspections summaries, to ensure they remain in a public and conspicuous place in the home. - █ 6/23/25

Directed Completion Date: 06/27/2025

Not Implemented (█ - 07/23/2025)

16c - Written Incident Report

2. 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 3/23/25, at approximately 10:00 a.m., staff person A reported to █ the administrator, that resident #1 smacked resident #2 in the face. The home did not report this incident to the Department until 4/22/25.

Plan of Correction

Directed (█ - 06/23/2025)

The home will report all reportable incidents and has reviewed the reportable incidents as a group including Administrator, Med techs, and staff.

DIRECTED:

Within 24 hours of receipt of the plan of correction - The administrator shall audit all reportable incidents and conditions daily to ensure all incidents and conditions are reported in accordance with Regulation 2600.16(c). Documentation of audits shall be kept. - █ 6/23/25

Within 5 days of receipt of the plan of correction - The administrator shall educate all staff persons on the requirements of Regulation 2600.16(c). Documentation of education shall be kept in accordance with regulation 2600.65(i). - █ 6/23/25

16c - Written Incident Report (continued)

Within 15 days of receipt of the plan of correction and at least quarterly thereafter - The administrator will review all reportable incidents and conditions as part of a quality management review to ensure all reportable incidents and conditions under Chapter 2600.16c are reported to the Department within the required time frame and by the required reporting method, and that patterns of incidents are identified and addressed. Documentation of the quality management review shall be kept, including the date and time of the meeting, the names of the staff persons who participated, and a summary of the items discussed during the review. - [REDACTED] 6/23/25

Directed Completion Date: 07/11/2025

Not Implemented ([REDACTED] - 07/23/2025)

25a - Written Contract and Review

3. Requirements

2600.

25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #10, admitted [REDACTED], does not have a resident-home contract completed.

Plan of Correction

Directed ([REDACTED] - 06/23/2025)

Resident #10 had a contract at Heartful Hands since [REDACTED] when [REDACTED] was admitted.

DIRECTED:

Within 24 hours of receipt of the plan of correction - The administrator will ensure a fully completed resident-home contract is in place for resident #10. - [REDACTED] 6/23/25

Within 5 days of receipt of the plan of correction - The administrator will review the contracts of all current residents to ensure a fully completed, signed contract is present in each record. The contracts will be available to the Department immediately upon request. - [REDACTED] 6/23/25

Within 5 days of receipt of the plan of correction - The administrator will develop and implement a document tracking system for new residents to ensure all contracts, including signatures, are completed prior to, or within 24 hours of admission. - [REDACTED] 6/23/25

Within 10 days of receipt of the plan of correction - All staff persons involved with resident admissions and contracts will be educated on the document tracking system. Documentation of education shall be kept in accordance with regulation 2600.65(i). - [REDACTED] 6/23/25

Directed Completion Date: 07/06/2025

Not Implemented ([REDACTED] - 07/23/2025)

42f - Mail Access

4. Requirements

42f - Mail Access (continued)

2600.

42.f. A resident has the right to receive and send mail.

- 2. Incoming mail may not be opened or read by staff persons unless upon the request of the resident or the resident's designated person.

Description of Violation

On 4/21/25 and 4/23/25, agents of the Department observed multiple stacks of unopened mail for residents #1, #2, #3 and #4 in the office of the home. Staff interviews indicate resident mail is not delivered to residents and the home's administrator, opens residents' mail.

Plan of Correction

Directed (- 06/23/2025)

Residents receive mail daily; residents often give mail back to administrator that they do not understand. Staff will each day open mail with the resident present and shred in the event they do not desire to keep the item that they have received,

DIRECTED:

Within 24 hours of receipt of the plan of correction - All resident mail that is in the office will be provided to the residents to whom it belongs. Future incoming mail will be provided to residents on the day it arrives at the home. - 6/23/25

Within 24 hours of receipt of the plan of correction - The resident's designated person shall be notified if a resident does not wish to open mail. The home will obtain permission from the resident or the resident's designated person prior to opening mail, and if permission is granted, mail will be opened promptly and explained to the resident. The home will not store unopened mail in the office. - 6/23/25

Within 10 days of receipt of the plan of correction - All staff will be educated on the requirement that all incoming mail addressed to a resident shall be given to the resident on the date it arrives in the home, may only be opened by the resident, unless the resident or the resident's designated person requests that staff open the mail; the only exception to this is mail order medications ordered by the home and addressed to a resident who cannot self-administer medications. Documentation of education shall be kept in accordance with regulation 2600.65(i). - 6/23/25

Directed Completion Date: 07/06/2025

Implemented (- 07/23/2025)

51 - Criminal Background Check

5. 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).

51 - Criminal Background Check (continued)

Description of Violation

Staff Person C, hired [REDACTED] does not have a criminal history background check completed.

Staff Person E, [REDACTED], who has been working in the home approximately [REDACTED], does not have a criminal history background check completed. The home did not provide a hire date.

Plan of Correction

Directed ([REDACTED] - 06/23/2025)

Staff person E has a criminal record check and results are dated back to the date [REDACTED] was hired. It was placed in the file and all items will be placed in new employee files at time of BG check

DIRECTED:

Within 24 hours of receipt of the plan of correction - Staff person E will have a criminal history background check completed or will be suspended from work until the Pennsylvania State Police criminal history background check is received. - [REDACTED] 6/23/25

Within 24 hours of receipt of the plan of correction - No employee will work unsupervised in the home until a completed criminal history background check is completed and reviewed by the administrator. - [REDACTED] 6/23/25

Within 5 days of receipt of the plan of correction - The administrator will develop and implement a tracking system to ensure new staff persons have all required documentation, including a criminal history background check performed by the Pennsylvania State Police. If a new employee has not been a PA resident for the past 2 years, an FBI check will also be conducted to ensure criminal history and hiring policies are in accordance with the Older Adult Protective Services Act and Pa Code Chapter 15. - [REDACTED] 6/23/25

Within 5 days of receipt of the plan of correction - The administrator or designee will review all employee records of current staff to ensure all have a criminal history background check completed and and hiring policies are in accordance with the Older Adult Protective Services Act and Pa Code Chapter 15. Documentation of this review will be kept. - [REDACTED] 6/25/25

Directed Completion Date: 07/01/2025

Not Implemented ([REDACTED] - 07/23/2025)

56 - Admin 20 Hours/Week

6. Requirements

2600.

56. Administrator Staffing - The administrator shall be present in the home an average of 20 hours or more per week, in each calendar month.

Description of Violation

On 4/21/25, [REDACTED] the home's administrator indicated that [REDACTED] is present in the home only an average of 11 hours per week.

Plan of Correction

Directed ([REDACTED] - 06/23/2025)

Administrator is present in the home 20 hours per week, however, was on leave due to recent [REDACTED] and had a designee during time of absence. This is acceptable per regulation.

56 - Admin 20 Hours/Week (continued)

DIRECTED:

Within 24 hours of receipt of the plan of correction - The home shall employ an administrator who meets the qualifications of 2600.53a and 2600.64a. The administrator shall be physically present in the home an average of 20 hours or more per week, in each calendar month. Documentation of the administrator credentials shall be kept in the administrator's record. A calendar shall be kept which includes the dates and hours the administrator is present in the home, a description of work performed each day, and will made available to the Department upon request. -

6/23/25

Directed Completion Date: 06/27/2025

Not Implemented () - 07/23/2025

60a - Staff/Support Plan

7. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

There was no qualified staff person to administer medications in the home from 4/1/25-4/21/25 on the 11:00 p.m.-7:00 a.m. shift. There are multiple residents who are prescribed prn medications, including residents #8 and #9.

Plan of Correction

Directed () - 06/23/2025

Heartful Hands is in the process of training and hiring med techs to have med techs cover the 11p-7a shift. We have employed a med trainer and will ensure that a overnight med tech is staffed. and/or on call to ensure this regulation is met.

DIRECTED:

Within 24 hours of receipt of the plan of correction - A qualified direct care staff person, who has successfully completed the requirements of regulation 2600.190a and has successfully completed a Department-approved diabetes patient education program within the past 12 months shall be present in the home at all times, including the overnight shift. - 6/25/25

Within 24 hours of receipt of the plan of correction - The administrator or designee will review the staffing schedule daily to ensure staffing needs, including a qualified staff person to administer all medications, to meet residents' needs based on the residents' assessments and support plans. - 6/25/25

Directed Completion Date: 06/27/2025

Not Implemented () - 07/23/2025

62 - Contact List

8. Requirements

2600.

62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

The list of staff persons provided to agents of the Department on 4/21/25 did not include staff person E's name, address or telephone number. Staff person E indicated [REDACTED] has been employed in the home for [REDACTED].

Plan of Correction

Directed ([REDACTED] - 06/25/2025)

Staff person E has been updated on the contact sheet for Personal Care home

DIRECTED:

Within 24 hours of receipt of the plan of correction - All management staff, including the administrator and designees, will be educated on this requirement. - [REDACTED] 6/25/25

Within 24 hours of receipt of the plan of correction - The administrator will update the staff list every time a new staff person starts or a current staff person leaves. An accurate and complete staff list, which includes names, addresses and telephone numbers of staff persons including substitute personnel and volunteers will be available to the Department immediately upon request. - [REDACTED] 6/25/25

Directed Completion Date: 06/27/2025

Implemented ([REDACTED] - 07/23/2025)

64a - Admin Training

9. Requirements

2600.

64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:
2. A 100-hour standardized Department-approved administrator training course.

Description of Violation

[REDACTED] administrator, has not completed the Department-approved competency-based training test with a passing score.

Plan of Correction

Directed ([REDACTED] - 06/25/2025)

Administrator received 100 training hours prior to taking test for PCH administrator, 100 hour course is required before test is available. Administrators document has been posted in the office.

DIRECTED:

Within 24 hours of receipt of the plan of correction - The home will employ a qualified administrator at all times. The current administrator will provide documentation of administrator qualifications, including the Certificate of Completion of the 100-hour course and passing of the Department-approved competency test to the Department. A copy of all documentation will be kept on-site at the home and available to the Department upon request. - [REDACTED] 6/25/25

64a - Admin Training (continued)

Directed Completion Date: 07/11/2025

Implemented (█) - 07/15/2025)

65a - FS Orientation 1st Day

10. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person C, hired in █, has not received orientation training in any of the topics in accordance with 65a.

Staff person E has been working in the home approximately █ however, not received orientation training in any of the topics in accordance with 2600.65a. The home did not provide an exact date of hire.

Repeat Violation: 7/28/23 et al

Plan of Correction

Directed (█) - 06/25/2025)

All staff persons receive orientation prior to hiring this will be documented and put in staff employment file to verify completion.

DIRECTED:

Within 24 hours of receipt of the plan of correction – Staff persons C and E will receive orientation training in all of the required topics under 2600.65(a). Documentation will be kept. - █ 6/25/25

65a - FS Orientation 1st Day (continued)

Within 15 calendar days of receipt of the plan of correction – The administrator or designated staff person will review all training records to ensure that all current staff persons have completed the required orientation training under 2600.65(a). In the event any staff person has not received this training, the training will be provided. Documentation will be kept. - [REDACTED] 6/25/25

Within 15 calendar days of receipt of the plan of correction – The administrator will create a tracking system to ensure that newly-hired staff persons receive orientation training in all topics under 2600.65(a) on or before the first work day and ensure that the documentation of this training is kept in the staff person’s record. - [REDACTED] 6/25/25

Within 15 calendar days of receipt of the plan of correction and at least quarterly thereafter – The home shall conduct a quality management review, which includes a review of all items specified in 2600.26b, as follows: (1) The reportable incident and condition reporting procedures. (2) Complaint procedures. (3) Staff person training. (4) Licensing violations and plans of correction, if applicable. (5) Resident or family councils, or both, if applicable. Documentation of the quality management review shall be kept, including the date and time of the meeting, the names of the staff persons who participated, and a summary of the items discussed during the review. - [REDACTED] 6/25/25

Directed Completion Date: 07/11/2025

Not Implemented ([REDACTED] - 07/23/2025)

65b - Rights/Abuse 40 Hours

11. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person C, hired in [REDACTED], has completed more than 40 hours of work in the home, and has not received orientation training in any of the topics in accordance with 65b.

Staff person D, date of hire, [REDACTED] has completed more than 40 hours of work in the home, and has not received orientation training in any of the topics in accordance with 65b.

Staff person E has been working in the home approximately [REDACTED], has completed more than 40 hours of work in the home, and has not received orientation training in any of the topics in accordance with 65b.

Repeat Violation: 7/28/23 et al

65b - Rights/Abuse 40 Hours (continued)

Plan of Correction

Directed () - 06/25/2025

All staff person have reviewed policies and completed orientation training this will be verified with a signed document by new hire and put in staff file.

DIRECTED:

Within 24 hours of receipt of the plan of correction – Staff persons C, D and E will receive orientation training in all of the required topics under 2600.65(b). Documentation will be kept. - () 6/25/25

Within 15 calendar days of receipt of the plan of correction – The administrator or designated staff person will review all training records to ensure that all current staff persons have completed the required orientation training under 2600.65(b). In the event any staff person has not received this training, the training will be provided. Documentation will be kept. - () 6/25/25

Within 15 calendar days of receipt of the plan of correction – The administrator will create a tracking system to ensure that newly-hired staff persons receive orientation training in all topics under 2600.65(b) within 40 scheduled working hours and ensure that the documentation of this training is kept in the staff person’s record. - () 6/25/25

Within 15 calendar days of receipt of the plan of correction and at least quarterly thereafter – The home shall conduct a quality management review, which includes a review of all items specified in 2600.26b, as follows: (1) The reportable incident and condition reporting procedures. (2) Complaint procedures. (3) Staff person training. (4) Licensing violations and plans of correction, if applicable. (5) Resident or family councils, or both, if applicable. Documentation of the quality management review shall be kept, including the date and time of the meeting, the names of the staff persons who participated, and a summary of the items discussed during the review. - () 6/25/25

Directed Completion Date: 07/11/2025

Not Implemented () - 07/23/2025

65c - Ancillary Staff Orientation

12. Requirements

2600.

65.c. Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

Description of Violation

Staff person E, () has been working in the home approximately (), and did not receive orientation training to their specific job functions as it relates to their position prior to working in that capacity. The home did not provide an exact date of hire.

Plan of Correction

Directed () - 06/25/2025

All staff person have reviewed policies and completed orientation training and this will be verified with a signed document by new hire and put in new employee file. All files will be audited and brought to regulatory standard.

DIRECTED:

65c - Ancillary Staff Orientation (continued)

Within 24 hours of receipt of the plan of correction – Staff persons E will receive a general orientation training to their specific job duties as required under 2600.65(c). Documentation will be kept. - [REDACTED] 6/25/25

Within 15 calendar days of receipt of the plan of correction – The administrator or designated staff person will review all training records to ensure that all current ancillary staff persons have completed the required orientation training under 2600.65(c). In the event any staff person has not received this training, the training will be provided. Documentation will be kept. - [REDACTED] 6/25/25

Within 15 calendar days of receipt of the plan of correction – The administrator will create a tracking system to ensure that newly-hired ancillary staff persons receive a general orientation to their specific job functions as it relates to their position - prior to working in that capacity - and ensure that the documentation of this training is kept in the staff person’s record. - [REDACTED] 6/25/25

Within 15 calendar days of receipt of the plan of correction and at least quarterly thereafter – The home shall conduct a quality management review, which includes a review of all items specified in 2600.26b, as follows: (1) The reportable incident and condition reporting procedures. (2) Complaint procedures. (3) Staff person training. (4) Licensing violations and plans of correction, if applicable. (5) Resident or family councils, or both, if applicable. Documentation of the quality management review shall be kept, including the date and time of the meeting, the names of the staff persons who participated, and a summary of the items discussed during the review. - [REDACTED] 6/25/25

Directed Completion Date: 07/11/2025

Not Implemented ([REDACTED] - 07/23/2025)

65d - Initial Direct Care Training

13. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

- 2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person D, hired [REDACTED], began providing unsupervised ADL services on approximately 7/1/24. However, the staff person did not successfully complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction

Directed ([REDACTED] - 06/25/2025)

Staff person completed and passed competency test all competency tests will be printed and added to employee file at time of completion. PCH will begin quarterly audit to ensure this maintained and regulation is upheld.

DIRECTED:

Within 24 hours of receipt of the plan of correction - Staff person D will be trained in all required areas under 2600.65d. Documentation will be kept. - [REDACTED] 6/25/25

Within 24 hours of receipt of the plan of correction - The administrator will review the records of all direct care

65d - Initial Direct Care Training (continued)

staff persons to ensure all have completed all required training under 2600.65d, including successful completion and passing the Department-approved direct care training course and passing of the competency test. Documentation of all training will be kept. - [REDACTED] 6/25/25

Within 15 calendar days of receipt of the plan of correction – The administrator will create a tracking system to ensure that newly-hired direct care staff persons receive training in all topics under 2600.65(d) before providing unsupervised ADL services, including successful completion and passing the Department-approved direct care training course and passing of the competency test. Documentation of this training is kept in the staff person's record. - [REDACTED] 6/25/25

Within 15 calendar days of receipt of the plan of correction and at least quarterly thereafter – The home shall conduct a quality management review, which includes a review of all items specified in 2600.26b, as follows: (1) The reportable incident and condition reporting procedures. (2) Complaint procedures. (3) Staff person training. (4) Licensing violations and plans of correction, if applicable. (5) Resident or family councils, or both, if applicable. Documentation of the quality management review shall be kept, including the date and time of the meeting, the names of the staff persons who participated, and a summary of the items discussed during the review. - [REDACTED] 6/25/25

Directed Completion Date: 07/11/2025

Not Implemented ([REDACTED] - 07/23/2025)

65e - 12 Hours Annual Training

14. Requirements

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

- 1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
- 2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Staff person F received only 6 hours of annual training during training year 2024.

Staff person G received only 6 hours of annual training during training year 2024.

Plan of Correction

Directed ([REDACTED] - 06/25/2025)

All staff will be required to take part in 12 hours of training annually. This will be documented and added to staff file. Administrator will coordinate a schedule and distribute the calendar to all employees to ensure regulation is met. Owner will review and ensure all staff are up to date with regulatory training in 2025. PCH home had consultant that reported this being completed in 2024. Training schedule will be created for onsite and online opportunities for PCH home staff.

DIRECTED:

Staff persons F and G will complete at least 12 hours annual training during training year 2025. - [REDACTED] 6/25/25

Within 15 calendar days of receipt of the plan of correction and at least quarterly thereafter – The home shall conduct a quality management review, which includes a review of all items specified in 2600.26b, as follows: (1) The reportable incident and condition reporting procedures. (2) Complaint procedures. (3) Staff person training. (4)

65e - 12 Hours Annual Training (continued)

Licensing violations and plans of correction, if applicable. (5) Resident or family councils, or both, if applicable. Documentation of the quality management review shall be kept, including the date and time of the meeting, the names of the staff persons who participated, and a summary of the items discussed during the review. - [REDACTED] 6/25/25

Directed Completion Date: 07/11/2025

Not Implemented ([REDACTED] - 07/23/2025)

65f - Training Topics

15. Requirements

2600.

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

- 2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
- 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.
- 7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Staff persons F and G did not receive training in the following topics during training year 2024:

- Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan
- Infection control and general principles of cleanliness and hygiene and areas associated with immobility such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration
- Care for residents with mental illness. The home serves numerous residents diagnosed with mental illness.

Plan of Correction

Directed ([REDACTED] - 06/25/2025)

Administrator is developing a new training plan for Heartful Hands

DIRECTED:

Within 5 days of receipt of the plan of correction - Staff persons F and G will receive training in the following topics:

- Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan
- Infection control and general principles of cleanliness and hygiene and areas associated with immobility such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration
- Care for residents with mental illness. The home serves numerous residents diagnosed with mental illness.

Within 15 calendar days of receipt of the plan of correction and at least quarterly thereafter – The home shall conduct a quality management review, which includes a review of all items specified in 2600.26b, as follows: (1) The reportable incident and condition reporting procedures. (2) Complaint procedures. (3) Staff person training. (4) Licensing violations and plans of correction, if applicable. (5) Resident or family councils, or both, if applicable. Documentation of the quality management review shall be kept, including the date and time of the meeting, the names of the staff persons who participated, and a summary of the items discussed during the review. - [REDACTED] 6/25/25

65f - Training Topics (continued)

Directed Completion Date: 07/11/2025

Not Implemented () - 07/23/2025

65g - Annual Training Content

16. 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:

- 2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

Description of Violation

Staff persons F and G did not receive training in emergency preparedness procedures and recognition and response to crises and emergency situations during training year 2024.

Plan of Correction

Directed () - 06/25/2025

All Staff will receive Emergency Preparedness Procedures and Recognition as well as Response to Crisis and Emergency Situations going forward. Administrator and facility and compliance staff will monitor and keep training log.

DIRECTED:

Within 5 days of receipt of the plan of correction - Staff persons F and G will receive training in receive training in emergency preparedness procedures and recognition and response to crises and emergency situations.

Within 15 calendar days of receipt of the plan of correction and at least quarterly thereafter – The home shall conduct a quality management review, which includes a review of all items specified in 2600.26b, as follows: (1) The reportable incident and condition reporting procedures. (2) Complaint procedures. (3) Staff person training. (4) Licensing violations and plans of correction, if applicable. (5) Resident or family councils, or both, if applicable. Documentation of the quality management review shall be kept, including the date and time of the meeting, the names of the staff persons who participated, and a summary of the items discussed during the review. - () 6/25/25

Directed Completion Date: 07/11/2025

Not Implemented () - 07/23/2025

66a - Staff Training Plan

17. Requirements

2600.

66.a. A staff training plan shall be developed annually.

Description of Violation

The home does not have an annual staff training plan developed for calendar year 2025.

Plan of Correction

Directed () - 06/25/2025

Administrator will complete an annual staff training plan for 2025

66a - Staff Training Plan (continued)

DIRECTED:

Within 5 days of receipt of the plan of correction - The administrator will complete an individualized, separate training plan for each staff person who works in the home. Each plan will include a list of courses planned for each staff person for the rest of 2025 and include all components of 2600.66b. The administrator will incorporate required training topics in accordance with the training requirements of § 2600.65(a)-(f), to ensure required training is completed annually. - [REDACTED] 6/25/25

Within 15 calendar days of receipt of the plan of correction and at least quarterly thereafter – The home shall conduct a quality management review, which includes a review of all items specified in 2600.26b, as follows: (1) The reportable incident and condition reporting procedures. (2) Complaint procedures. (3) Staff person training. (4) Licensing violations and plans of correction, if applicable. (5) Resident or family councils, or both, if applicable. Documentation of the quality management review shall be kept, including the date and time of the meeting, the names of the staff persons who participated, and a summary of the items discussed during the review. - [REDACTED] 6/25/25

Directed Completion Date: 07/11/2025

Not Implemented ([REDACTED] - 07/23/2025)

88a - Surfaces

18. 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 4/21/25, at 9:33 a.m., the exit door leading to the outside of the home from bathroom #3, did not fully close. There was a gap of approximately 3 inches.

Plan of Correction

Directed ([REDACTED] - 06/26/2025)

[REDACTED] - UNACCEPTABLE PLAN [REDACTED] 6/25/25

DIRECTED:

Within 24 ours of receipt of the plan of correction - If a "Not an Exit" sign has been posted on this door, it will be removed. - [REDACTED] 6/25/25

Within 24 ours of receipt of the plan of correction - The door leading to the outside of the home in bathroom 3 will be repaired or replaced so it will close securely. [REDACTED] 6/25/25

Within 24 ours of receipt of the plan of correction - The administrator will complete a walk-through of the home at least weekly to ensure all floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards. Documentation will be kept. - [REDACTED] 6/25/25

Directed Completion Date: 06/27/2025

Not Implemented ([REDACTED] - 07/23/2025)

123b - Emergency Procedures Posted

19. Requirements

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures are not posted in a conspicuous and public place in the home.

Plan of Correction

Directed () - 06/26/2025

Emergency procedures are posted downstairs in the Personal Care Home in the hallway. Picture will be uploaded

DIRECTED :

Within 24 hours of receipt of the plan of correction - The administrator will complete a walk-through of the home at least weekly to ensure the emergency procedures and all required postings are posted in public and conspicuous places. Documentation will be kept. - 6/25/25

Directed Completion Date: 06/27/2025

Not Implemented () - 07/23/2025

132a - Monthly Fire Drill

20. Requirements

2600.

132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

There were no unannounced fire drills conducted during the months of April, June and October 2024.

Plan of Correction

Directed () - 06/26/2025

Going forward there will be a fire drill every month at Heartful Hands, Administrator and designee will keep a log of a fire drill conducted monthly

DIRECTED :

Within 5 days of receipt of the plan of correction - The administrator will ensure a fire drill is completed monthly, and all residents are evacuated to a public thoroughfare or to a fire-safe area. The administrator will observe fire drills in July and August 2025 to ensure all proper procedures are followed, and review the fire drill log to ensure all information is recorded completely and accurately. - 6/25/25

Within 5 days of receipt of the plan of correction - All staff persons and residents will be educated on the monthly, unannounced fire drill requirement. Documentation will be kept. - 6/25/25

Directed Completion Date: 06/27/2025

Implemented () - 07/23/2025

132c - Fire Drill Records

21. Requirements

2600.

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

The fire drill record for the drill conducted on 9/5/24, indicates the time of the drill was 3:32, with no am or pm designation, and the same evacuation time of 3:32.

The fire drill on 9/16/24 indicates it was a "nite" drill; however, there are two numbers in the time column, 3:57 and 11:30, therefore, it is unable to be determined the time of day they were conducted, if 2 were completed on that date.

Plan of Correction

Directed (█) - 06/26/2025)

9/5/24 the fire drill was at 3:32pm and 9/16/24 the fire drill was conducted at 11:30pm, however going forward all fire drill recording will be fully completed with appropriate time stamps

Within 5 days of receipt of the plan of correction - The administrator will ensure a fire drill is completed monthly, and all residents are evacuated to a public thoroughfare or to a fire-safe area. The administrator will observe fire drills in July and August 2025 to ensure all proper procedures are followed, and review the fire drill log to ensure all information is recorded completely and accurately. - █ 6/25/25

Within 5 days of receipt of the plan of correction - All staff persons and residents will be educated on the monthly, unannounced fire drill requirement and the required components of the fire drill record. Documentation will be kept. - █ 6/25/25

Directed Completion Date: 06/27/2025

Not Implemented (█) - 07/23/2025)

132d - Evacuation

22. 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

During the fire drill on 12/10/24 at 1:18 p.m., the fire drill record indicates there were 26 resident present in the home and that 26 residents evacuated; however, the "any problems" column in indicates a resident "refused to go,"

During the fire drills on 1/28/25 and 2/27/25, there were 29 residents present in the home; however, only 28 residents evacuated to a public thoroughfare outside of the building. The home does not have an interior fire-safe area, according to the letter dated 7/18/24 from the fire safety expert.

Repeat violation: 7/28/23 et al

132d - Evacuation (continued)

Plan of Correction**Directed (█ - 06/26/2025)**

There were 29 residents in the home however one residents was out for the day the report was completed wrong. All staff will be educated and fire drills will be monitored. The Facility manager will ensure all drills are completed and PCH will seek outside contractor/consultant to train and support PCH to remain compliant with regulation.

DIRECTED:

Within 24 hours of receipt of the plan of correction - The administrator will ensure all residents present in the home at the time of a fire drill are evacuated to the designated meeting place outside the home. - █ 6/25/25

Within 15 days of receipt of the plan of correction - The administrator will personally observe the July 2025 unannounced fire drill, which will be conducted during sleeping hours, A different resident occupied zone will be designated as the affected fire area for each future fire drill. The fire drills will be conducted using the number of staff regularly scheduled during sleeping hours and not when additional staff is scheduled. All residents will evacuate out of their individual rooms to a designated meeting area within a fire safe area or to the designated outside meeting area. Documentation will be kept in accordance with 2600.132c. - █ 6/25/25

Within 15 days of receipt of the plan of correction - All staff will be educated on the proper procedures for evacuation during drills or actual fires, including evacuating all residents out of their individual rooms to the designated meeting area outside of the home. Documentation of training will be kept. - █ 6/25/25

Directed Completion Date: 07/11/2025

Implemented (█ - 07/23/2025)

132e - Fire Drill Sleeping Hours

23. Requirements

2600.

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

Description of Violation

The last fire drill conducted during sleeping hours, was on 9/16/24, indicating the time, 3:57 and 11:30. However, it does not indicate a.m. or p.m. In addition, the previous fire drill conducted during sleeping hours was 3/30/24, at 12:02 a.m.

Repeat Violation: 7/28/23 et al

Plan of Correction**Directed (█ - 06/26/2025)**

On 9/16/24 the fire drill was conducted at 11:30pm, however going forward the fire drill log will be completed correctly. All staff will be educated and fire drills will be monitored. The Facility manager will ensure all drills are completed and PCH will seek outside contractor/consultant to train and support PCH to remain compliant with regulation.

DIRECTED:

132e - Fire Drill Sleeping Hours (continued)

Within 15 days of receipt of the plan of correction - All staff will be educated on the proper procedures for evacuation during drills or actual fires, including rotating exits and evacuating all residents out of their individual rooms to the designated meeting area outside of the home. Documentation of training will be kept. - [REDACTED] 6/25/25

Within 15 days of receipt of the plan of correction - The administrator will personally observe the July 2025 unannounced fire drill, which will be conducted during sleeping hours, A different resident occupied zone will be designated as the affected fire area for each future fire drill. The fire drills will be conducted using the number of staff regularly scheduled during sleeping hours and not when additional staff is scheduled. All residents will evacuate out of their individual rooms to a designated meeting area within a fire safe area or to the designated outside meeting area. Documentation will be kept in accordance with 2600.132c. - [REDACTED] 6/25/25

Directed Completion Date: 07/11/2025

Not Implemented ([REDACTED] - 07/23/2025)

132f - Alternate Exit Routes

24. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The side door was the only exit route used during the fire drills conducted on 9/5/24, 9/16/24, 11/8/24, 12/10/24, 1/28/25, 2/27/25 and 3/25/25.

Plan of Correction

Directed ([REDACTED] - 06/26/2025)

Heartful Hands will begin to incorporate using multiple exits during fire drills so that residents have safe alternates and are knowledgeable and familiar with other routes.

DIRECTED:

Within 15 days of receipt of the plan of correction - All staff will be educated on the proper procedures for evacuation during drills or actual fires, including using rotating exits and evacuating all residents out of their individual rooms to the designated meeting area outside of the home. Documentation of training will be kept. - [REDACTED] 6/25/25

Within 15 days of receipt of the plan of correction - The administrator will personally observe the July 2025 unannounced fire drill, which will be conducted during sleeping hours, A different resident occupied zone will be designated as the affected fire area for each future fire drill. The fire drills will be conducted using the number of staff regularly scheduled during sleeping hours and not when additional staff is scheduled. All residents will evacuate out of their individual rooms to a designated meeting area within a fire safe area or to the designated outside meeting area. Documentation will be kept in accordance with 2600.132c. - [REDACTED] 6/25/25

Directed Completion Date: 07/11/2025

Implemented ([REDACTED] - 07/23/2025)

141b1 - Annual Medical Evaluation

25. Requirements

141b1 - Annual Medical Evaluation (continued)

2600.

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

Description of Violation

The most recent medical evaluation for resident #5 was completed on [REDACTED]

The most recent medical evaluation for resident #6 was completed on [REDACTED]

The most recent medical evaluation for resident #7 was completed on [REDACTED]

Plan of Correction

Directed ([REDACTED] - 06/26/2025)

Medical Evaluations for residents 5,6, & 7 were completed on 1/5/25. Administrator and admin trainer will ensure all evaluations are in resident files to ensure files are up to date.

DIRECTED:

Within 15 days of receipt of the plan of correction - The administrator or designated staff person will review all current resident files to ensure a current medical evaluation has been completed and is present in the residents' records. Documentation will be kept- [REDACTED] 6/25/25

Within 15 days of receipt of the plan of correction - All staff persons involved with the medical evaluation process will be educated on the required contents of the medical evaluation and timeframes for completion. Documentation will be kept. [REDACTED] 6/25/25

Within 15 days of receipt of the plan of correction - The administrator will develop a tracking system to ensure all medical evaluation are completed at least annually, and when a resident has a significant change in condition. - [REDACTED] 6/25/25

Directed Completion Date: 07/11/2025

Not Implemented ([REDACTED] - 07/23/2025)

182b - Prescription Medication

26. Requirements

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

Resident #8 is prescribed Mounjaro 5mg/0.5ml, inject once a week, a subcutaneous GLP-1 agonist injectable medication. This medication is not insulin.

182b - Prescription Medication (continued)

Staff person G administered this medication to resident #8 on 4/4/24, 4/11/24 and 4/18/25. Direct care staff person G is not certified to administer Mounjaro.

Plan of Correction

Directed () - 06/26/2025

All Med techs have received updated Diabetes Training May 9 2025. PCH home will apply for the waiver and seek to have staff trained. There are currently no residents that are taken the medication that requires special training. PCH will work with () Pharmacy in the event we have a new admit during the training time for our trained med techs. PCH is currently working to train and/or hire 2 more med techs to ensure we are fully staffed to meet regulation.

DIRECTED:

Within 24 hours of receipt of the plan of correction - The administrator will ensure that only a licensed medical professional, as specified in 2600.182b, will administer the subcutaneous GLP-1 agonist medication Mounjaro to resident #8. - () 6/25/25

Within 24 hours of receipt of the plan of correction - The administrator will ensure that only a licensed medical professional, as specified in 2600.182.b, will administer the subcutaneous GLP-1 agonist medication to any resident that is prescribed one of these medications. - () 6/25/25

Directed Completion Date: 06/27/2025

Implemented () - 07/23/2025

185a - Implement Storage Procedures

27. 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 #9 is prescribed Diphenhydramine 25mg, take 1 cap by mouth 3 times daily when needed. On 4/23/25, the medication was not available in the home.

Plan of Correction

Directed () - 06/26/2025

Heartful Hands going forward will make sure all Residents have the medication they are prescribed and that it is available. We have staffed a new supervisor of medication that monitor and ensure that all medications are refilled, distributed and monitored daily. an audit will be conducted to ensure PCH is complaint with regulation.

DIRECTED:

Within 24 hours of receipt of the plan of correction - The administrator will ensure all of the medications for resident #9 are available in the home. - () 6/25/25

185a - Implement Storage Procedures (continued)

Within 5 days of receipt of the plan of correction - All staff persons involved in medication administration will be educated on this requirement and the home's procedures for ordering medication. Documentation will be kept. - [REDACTED] 6/25/25

Within 5 days of receipt of the plan of correction - A designated staff person will audit resident prescriptions, physician orders, medications and the MAR, to ensure all prescribed medications are available in the home for administration. Documentation will be kept. - [REDACTED] 6/25/25

Within 5 days of receipt of the plan of correction - A designated staff person will audit the medication cart and MAR's at least weekly to ensure prescribed medications are available in the home, including PRN medications. Documentation will be kept. - [REDACTED] 6/25/25

Within 5 days of receipt of the plan of correction - The administrator will develop and implement a system as part of the home's medication policy, to ensure prescribed medications are available in the home for administration at all times. - [REDACTED] 6/25/25

Directed Completion Date: 07/01/2025

Not Implemented ([REDACTED] - 07/23/2025)

187a - Medication Record

28. Requirements

2600.

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

- 3. Name of medication.
- 4. Strength.
- 5. Dosage form.

Description of Violation

Resident #2 is prescribed Hydrocortisone 1% cream, apply topically to affected area twice daily. This medication was administered on 4/21/25 at 8:00 a.m.; however, it is not included on the resident's April 2025 medication administration record (MAR).

Plan of Correction

Directed ([REDACTED] - 06/26/2025)

All Medication for each resident has been updated in the MAR. Owner will be onsite to ensure this has been completed.

DIRECTED:

Within 24 hours of receipt of the plan of correction - The administrator will ensure the MAR for resident #2 is updated to include the identified medication. - [REDACTED] 6/25/25

187a - Medication Record (continued)

Within 5 days of receipt of the plan of correction - All staff persons involved in medication administration will be educated on this requirement to ensure all medications are listed on the MAR. Documentation will be kept. - [REDACTED] 6/25/25

Within 5 days of receipt of the plan of correction - A designated staff person will audit resident prescriptions, physician orders, medications and the MAR, to ensure all prescribed medications are available in the home for administration. Documentation will be kept. - [REDACTED] 6/25/25

Within 5 days of receipt of the plan of correction - A designated staff person will audit the medication cart and MARs at least weekly to ensure prescribed medications are indicated on the MAR. Documentation will be kept. - [REDACTED] 6/25/25

Directed Completion Date: 07/01/2025

Not Implemented ([REDACTED] - 07/23/2025)

187b - Date/Time of Medication Admin.

29. 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 4/3/25 at 8:00 a.m., resident #8 was administered Enalapril 20mg. However, staff person F did not initial the MAR after administering the medication.

Plan of Correction

Directed ([REDACTED] - 06/26/2025)

Staff person F has been counseled on initialing the MAR after administering medication. Medication trainer will monitor staff person F. All med techs will received training that is required per regulation. Med trainer will hold reminder meeting with med techs to ensure they can demonstrate knowledge of documentation in the MAR.

DIRECTED:

Within 5 days of receipt of the plan of correction - All staff persons who administer medication will be reeducated on proper documentation procedures. This retraining shall include the requirement of recording the administration of medication at the time the medication is administered by the staff person who administers the medication. Documentation will be kept. - [REDACTED] 6/25/25

Within 5 days of receipt of the plan of correction - A designated staff person will monitor the MAR daily to ensure all medication administration documentation is complete, and accurate. Documentation will be kept. - [REDACTED] 6/25/25

Directed Completion Date: 07/01/2025

Not Implemented ([REDACTED] - 07/23/2025)

190b - Insulin Injections

30. Requirements

2600.

190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Staff persons F and G have not successfully completed a Department-approved diabetes patient education in the last 12 months, However, from 4/2/25 through 4/20/25 staff persons F and G administered insulin to resident #9.

Plan of Correction

Directed (█) - 06/26/2025)

All Med techs received Diabetes training May 9 2025. diabetic training will be hosted on site three times a year to ensure all med techs are in compliance with he regulation. PCH will ensure employee schedules are implemented to meet regulation.

DIRECTED:

Within 24 hours of receipt of the plan of correction - The administrator or designee will review the staffing schedule daily to ensure a qualified direct care staff person, who has successfully completed the requirements of regulation 2600.190a and has successfully completed a Department-approved diabetes patient education program within the past 12 months is present in the home at all times, including the overnight shift. - █ 6/25/25

Within 24 hours of receipt of the plan of correction - The administrator will review the records of all direct care staff persons who administer medications, to ensure all staff have completed all required training under 2600190(a) and 190(b). Documentation of all training will be kept. - █ 6/25/25

Within 15 calendar days of receipt of the plan of correction – The administrator will create a tracking system to ensure that staff persons who administer medications have completed all required training under 2600190(a) and 190(b), and continued observations and annual training are completed as required. Documentation of this training will kept. - █ 6/25/25

Within 15 calendar days of receipt of the plan of correction and at least quarterly thereafter – The home shall conduct a quality management review, which includes a review of all items specified in 2600.26b, as follows: (1) The reportable incident and condition reporting procedures. (2) Complaint procedures. (3) Staff person training. (4) Licensing violations and plans of correction, if applicable. (5) Resident or family councils, or both, if applicable. Documentation of the quality management review shall be kept, including the date and time of the meeting, the names of the staff persons who participated, and a summary of the items discussed during the review. - █ 6/25/25

Directed Completion Date: 06/27/2025

Not Implemented (█) - 07/23/2025)

224a - Preadmission Screen Form

31. 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

Resident #2 was admitted to the home on [REDACTED] however, a preadmission screening form was not completed.

Resident #10 was admitted to the home on [REDACTED] however, a preadmission screening form was not completed.

Plan of Correction

Directed ([REDACTED] - 06/26/2025)

Prescreening forms will be completed for all newly admitted residents going forward for Heartful hands. An intake packet will be developed. PCH administrator and administrator trainee will be in charge of ensuring regulation is met and new residents have a complete intake to the PCH

DIRECTED:

Within 5 days of receipt of the plan of correction - The administrator or designated staff person will create and implement a document tracking system for new residents to ensure all residents have a preadmission screening completed within 30 days prior to admission, documented on the required form, to determine that the needs of the resident can be met by the services provided by the home. - [REDACTED] 6/25/25

Within 5 days of receipt of the plan of correction - All staff persons involved with resident admissions will be educated regarding the documentation system. Documentation will be kept. - [REDACTED] 6/25/25

Directed Completion Date: 07/01/2025

Not Implemented ([REDACTED] - 07/23/2025)

225a - Assessment 15 Days

32. 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, admitted [REDACTED] does not have a written assessment completed.

Resident #10, admitted [REDACTED], does not have an written assessment completed.

Plan of Correction

Directed ([REDACTED] - 06/26/2025)

Resident #2 has left the PCH and Resident 10 has an assessment completed. Assessments will be added to client file within regulatory standard. Administrator and admin trainee will be responsible. PCH will complete an audit of all files to ensure this is completed.

225a - Assessment 15 Days (continued)

DIRECTED:

Within 15 days of receipt of the plan of correction - The administrator or designee will review the assessments of all current residents to ensure a timely, complete and accurate assessment is present in each record, including all diagnoses, special diets, and other needed services. Documentation will be kept. - [REDACTED] 6/25/25

Within 15 days of receipt of the plan of correction - All staff persons completing assessments will be educated regarding the completion and accuracy of the document including required timeframes, documentation of all diagnoses, special dietary needs, and needed services. Documentation of the training will be kept.- [REDACTED] 6/25/25

Within 15 days of receipt of the plan of correction - The administrator will review all new resident assessments for accuracy and completion. - [REDACTED] 6/25/25

Within 15 days of receipt of the plan of correction - The administrator will develop a tracking system to ensure all resident assessments are completed in the required timeframes. - [REDACTED] 6/25/25

Directed Completion Date: 07/11/2025

Not Implemented ([REDACTED] - 07/23/2025)

225c - Additional Assessment

33. Requirements

2600.

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

- 1. Annually.

Description of Violation

The most recent assessment for resident #5 was completed on [REDACTED]

The most recent assessment for resident #6 was completed on [REDACTED]

The most recent assessment for resident #10 was completed on [REDACTED]

Plan of Correction

Directed ([REDACTED] - 06/26/2025)

Residents 5, 6, and 10 have updated assessments. Assessments will be added to client file within regulatory standard. Administrator and admin trainee will be responsible. PCH will complete an audit of all files to ensure this is completed.

DIRECTED:

Within 15 days of receipt of the plan of correction - The administrator or designee will review the assessments of all current residents to ensure a timely, complete and accurate assessment is present in each record, including all diagnoses, special diets, and other needed services. Documentation will be kept. - [REDACTED] 6/25/25

225c - Additional Assessment (continued)

Within 15 days of receipt of the plan of correction - All staff persons completing assessments will be educated regarding the completion and accuracy of the document including required timeframes, documentation of all diagnoses, special dietary needs, and needed services. Documentation of the training will be kept. - [REDACTED] 6/25/25

Within 15 days of receipt of the plan of correction - The administrator will review all newly completed resident assessments for accuracy and completion. - [REDACTED] 6/25/25

Within 15 days of receipt of the plan of correction - The administrator will develop a tracking system to ensure all resident assessments are completed in the required timeframes. - [REDACTED] 6/25/25

Directed Completion Date: 07/11/2025

Not Implemented ([REDACTED] - 07/23/2025)

227a - Support Plan 30 Days

34. Requirements

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #2, admitted [REDACTED] does not have a written support plan completed.

Plan of Correction

Directed ([REDACTED] - 06/26/2025)

Resident 2 is no longer with Heartful Hands. Assessments will be added to client file within regulatory standard. Administrator and admin trainee will be responsible. PCH will complete an audit of all files to ensure all residents have a support plan.

DIRECTED:

Within 15 days of receipt of the plan of correction - All staff persons completing support plans will be educated regarding the completion and accuracy of the document, including timeframes for completion and how the document must address how the home will meet each resident's care needs. Documentation of the training will be kept. - [REDACTED] 6/25/25

Within 15 days of receipt of the plan of correction - The administrator or designee will review the support plans of all current residents to ensure a individualized, current, complete and accurate support plan is present in each record. Documentation will be kept. - [REDACTED] 6/25/25

Within 15 days of receipt of the plan of correction - The administrator or designated staff person will review all newly completed resident support plans to ensure completion and accuracy including each residents care, needs and services. - [REDACTED] 6/25/25

Directed Completion Date: 07/11/2025

Not Implemented ([REDACTED] - 07/23/2025)

251a - Record for Each Resident

35. Requirements

2600.

251.a. A separate record shall be kept for each resident.

Description of Violation

The home has no record for resident #2, admitted on [REDACTED]

The home has no record for resident #10, admitted on [REDACTED]

Plan of Correction

Directed ([REDACTED] - 06/26/2025)

Resident 2 has a record it will be placed in [REDACTED] file. [REDACTED] is no longer at the PCH. Heartful Hands and resident 10 has a record this will be placed in file and owner will ensure this has been completed while onsite 6/24-6/27/2025.

DIRECTED:

Within 5 days of receipt of the plan of correction - The administrator will review all resident files to ensure each resident has [REDACTED] own record containing all of the contents required by § 2600.252. - [REDACTED] 6/25/25

Within 5 days of receipt of the plan of correction - The entire record of each discharged resident, including resident #2 shall be kept for at least 3 years following the resident's discharge from the home or until any audit or litigation is resolved, in accordance with §2600.253a. - [REDACTED] 6/25/25

Directed Completion Date: 06/30/2025

Implemented ([REDACTED] - 07/23/2025)

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

Facility Information

Name: *HEARTFUL HANDS LLC* License #: *45370* License Expiration: *11/29/2025*
Address: *514 MITCHELL AVENUE, CLAIRTON, CLARITON, PA 15025*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *HEARTFUL HANDS LLC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *06/14/2010* Issued By: *City of Clairton*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *26* Waking Staff: *20*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Incident* Exit Conference Date: *06/17/2025*

Inspection Dates and Department Representative

06/17/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *36* Residents Served: *25*

Secured Dementia Care Unit

In Home: *No* Area: Capacity: Residents Served:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *25* Are 60 Years of Age or Older: *19*
Diagnosed with Mental Illness: *25* Diagnosed with Intellectual Disability: *5*
Have Mobility Need: *1* Have Physical Disability: *0*

Inspections / Reviews

06/17/2025 - Partial

Lead Inspector: *Cindy Kirsch* Follow-Up Type: *POC Submission* Follow-Up Date: *07/10/2025*

Inspections / Reviews (*continued*)

07/10/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: 07/16/2025
Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 07/14/2025

07/16/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: 07/16/2025
Reviewer: [REDACTED] Follow-Up Type: Bypass Document Submission

07/23/2025 - Bypass Document Submission

Submitted By: [REDACTED] Date Submitted: 07/16/2025
Reviewer: [REDACTED] Follow-Up Type: Enforcement

141b1 - Annual Medical Evaluation

1. Requirements

2600.

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

Description of Violation

Resident #1's most recent medical evaluation was completed on [REDACTED]

Resident #2's most recent medical evaluation was completed on [REDACTED]

Plan of Correction**Directed ([REDACTED] - 07/16/2025)**

Heartful Hands will be in compliance as we are adding a medical calendar to ensure medical evaluations are completed annually. Medical evaluation will be completed on 7/14/2025 at Heartful Hands. Staff in person training will be [REDACTED] to ensure all staff receive the expected information for compliance according to DHS. [Unacceptable completion date. - [REDACTED] 7/16/25]

Heartful Hands will also have quarterly reviews to ensure compliance is being maintained for all residents in the PCH.

Heartful Hands is current reviewing [REDACTED] resident files to ensure compliance, we are working with a doctor and nurse practitioner to update all resident evaluation and assessments.

All intake and direct care staff have received the following information:

RESIDENT HEALTH

§ 2600.141. Resident medical evaluation and health care.

(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.

(b) A resident shall have a medical evaluation:

(1) At least annually.

(2) If the medical condition of the resident changes prior to the annual medical evaluation.

We are auditing all resident files and will be completed by suggested date and will have quarterly reviews to ensure all residents files are in compliance with 2600.141.b.1.

We will also have agency calendar reminders dating back 45 before documentation is due.

141b1 - Annual Medical Evaluation (continued)

DIRECTED:

Within 1 day of receipt of the plan of correction - The administrator or designated staff person will review all current resident files to ensure a current medical evaluation has been completed and is present in the residents' records. Documentation will be kept- [REDACTED] 7/16/25

Within 1 day of receipt of the plan of correction - All staff persons involved with the medical evaluation process will be educated on the required contents of the medical evaluation and timeframes for completion. Documentation will be kept. - [REDACTED] 7/16/25

Within 1 day of receipt of the plan of correction - The administrator will develop a tracking system to ensure all medical evaluation are completed at least annually, and when a resident has a significant change in condition. - 7/16/25

Directed Completion Date: 07/17/2025

Not Implemented ([REDACTED] - 07/23/2025)

225c - Additional Assessment

2. Requirements

2600.

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

- 1. Annually.

Description of Violation

Resident #1's most recent assessment was completed on [REDACTED]

Resident #2's most recent assessment was completed on [REDACTED]

Plan of Correction

Directed ([REDACTED] - 07/16/2025)

Heartful Hands will be in compliance as we are adding a medical calendar to ensure medical evaluations and assessments are completed annually. Medical evaluation and assessments will be completed on 7/14/2025 at Heartful Hands.

Staff in person training will be held within two weeks of accepted plan to ensure all staff have been trained.

We are doing quarterly file reviews to ensure DHS compliance with annual assessment unless needed before that date.

Heartful Hands will also have quarterly reviews to ensure compliance is being maintained for all residents in the PCH for evaluations and assessments related to regulation 2600.225c.

Heartful Hands compliance staff have been provided information according to:

Pennsylvania, citation "2600. 225. c." refers to regulations regarding resident assessments in personal care homes, specifically addressing the requirement for additional assessments beyond the annual review.

Here's a breakdown:

225c - Additional Assessment (continued)

2600: This indicates the Title or Chapter of the Pennsylvania Code dealing with regulations for Personal Care Homes.

225: This section focuses on resident assessments within these facilities.

c.: This subsection outlines the conditions under which additional assessments are required, beyond the routine annual assessment. These include:

Annually.

If the resident's condition significantly changes prior to the annual assessment.

Heartful Hands will an update/complete new assessment.

In essence, these regulations ensure that personal care homes regularly assess residents' needs, especially when their health or circumstances change, in order to provide appropriate care and support.

DIRECTED:

Within 1 day of receipt of the plan of correction - The administrator or designee will review the assessments of all current residents to ensure a timely, complete and accurate assessment is present in each record, including all diagnoses, special diets, and other needed services. Documentation will be kept. - [REDACTED] 7/16/25

Within 1 day of receipt of the plan of correction - All staff persons completing assessments will be educated regarding the completion and accuracy of the document including required timeframes, documentation of all diagnoses, special dietary needs, and needed services. Documentation of the training will be kept.- [REDACTED] 7/16/25

Within 1 day of receipt of the plan of correction - The administrator will review all newly completed resident assessments for accuracy and completion.- [REDACTED] 7/16/25

Within 1 day of receipt of the plan of correction - The administrator will develop a tracking system to ensure all resident assessments are completed in the required timeframes. - [REDACTED] 7/16/25

Directed Completion Date: 07/17/2025

Not Implemented ([REDACTED] - 07/23/2025)