

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

November 6, 2025

[REDACTED]
VALLEY MEDICAL FACILITIES INC
[REDACTED]
[REDACTED]

RE: HERITAGE VALLEY SENIOR LIVING
COMMUNITY
30 HECKEL ROAD
MCKEES ROCKS, PA, 15136
LICENSE/COC#: 45191

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/17/2025, 09/18/2025 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 VALLEY SENIOR LIVING COMMUNITY **License #:** 45191 **License Expiration:** 07/01/2026
Address: 30 HECKEL ROAD, MCKEES ROCKS, PA 15136
County: ALLEGHENY **Region:** WESTERN

Administrator

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

Legal Entity

Name: VALLEY MEDICAL FACILITIES INC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP **Date:** 09/26/1997 **Issued By:** Dept. of Labor and Industry
Type: Other **Date:** 04/30/2021 **Issued By:** Allegheny County Health Department

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 105 **Waking Staff:** 79

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal **Exit Conference Date:** 09/18/2025

Inspection Dates and Department Representative

09/17/2025 - On-Site: [REDACTED]
09/18/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
License Capacity: 107 **Residents Served:** 65

Secured Dementia Care Unit
In Home: Yes **Area:** 1st Floor Memory Care **Capacity:** 17 **Residents Served:** 17

Hospice
Current Residents: 4

Number of Residents Who:
Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 64
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 1
Have Mobility Need: 40 **Have Physical Disability:** 0

Inspections / Reviews

09/17/2025 Full
Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 10/05/2025

Inspections / Reviews *(continued)*

10/15/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/27/2025

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 10/20/2025

10/21/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/27/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 10/27/2025

11/06/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/27/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

18 - Compliance With Laws

1. 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 Standard Act, enacted [REDACTED], requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. If the carbon monoxide alarm operates by a battery, the battery may not be removed for any length of time beyond that necessary to change the battery. The battery must be labeled with the date of installation and replaced at least once annually.

The home has a gas boiler. On [REDACTED] at approximately 12:30 pm, the battery in the carbon monoxide alarm located outside of the boiler room was not dated when it was installed.

Plan of Correction

Accept [REDACTED] - 10/15/2025)

Plan of correction:

- The battery in the carbon monoxide detector alarm located outside of the boiler room was dated by the Maintenance Director on 9/29/2025. (see attached picture)
- An audit was conducted on 9/30/2025 by the Maintenance Director to ensure all carbon monoxide detectors received new batteries and were dated. (See attached completed audit)
- Current maintenance staff will be educated by the Executive Director on Regulation 18 Applicable Health and Safety Laws by 10/17/2025.
- The preventive maintenance program will be updated by the Maintenance Director to include yearly changes of batteries in carbon monoxide detectors and the dating of the batteries.

Licensee's Proposed Overall Completion Date: 10/17/2025

Implemented [REDACTED] 11/05/2025)

54a - Direct Care Staff

2. Requirements

2600.

54.a. Direct care staff persons shall have the following qualifications:

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff persons C and E do not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry. The home uses an outside screening company to verify education, however, the home does not have a copy of the educational credentials.

Plan of Correction

Directed [REDACTED] - 10/15/2025)

Plan of correction:

- A copy of educational credentials for staff persons C and E will be obtained by 10/17/2025 by the HR department.
- An audit of all direct care staff to determine whether copies of educational credentials are needed will be conducted by the HR department by 10/17/2025.

54a Direct Care Staff (continued)

- The Executive Director will provide education to the HR staff on 2600.54a Direct care staff shall have the following qualifications by 10/17/2025.
- A monthly audit of new hires to ensure educational credentials are obtained will be started on 10/24/2025 and conducted for 3 months by the HR department.

A copy of the original diplomas or other proof of a minimum of high school education will be obtained from the staff persons or background screening company and kept in the staff records. [REDACTED] 10/15/25

Directed Completion Date: 10/24/2025

Implemented [REDACTED] - 11/05/2025)

64a - Admin Training

3. Requirements

2600.

64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:

1. An orientation program approved and administered by the Department.
3. A Department-approved competency-based training test with a passing score.

Description of Violation

Staff person D, the home's administrator, has not completed an orientation program approved and administered by the Department.

Staff person D, the home's administrator, has not completed the Department approved competency based Administrator training test.

Plan of Correction

Accept [REDACTED] - 10/15/2025)

See atPlan of correction

- Staff person D took the Department approved competency based Administrator training test and passed it in July of 2019. (See attached transcript). Staff person D is scheduled to complete the orientation program by the Department on 10/17/2025.
- HR will provide education to staff person D on Regulation 64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following by 10/17/2025. tached.

Licensee's Proposed Overall Completion Date: 10/17/2025

Implemented [REDACTED] - 11/05/2025)

65a - FS Orientation 1st Day

4. 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.

65a - FS Orientation 1st Day (continued)

- 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, whose first day of work was [REDACTED] did not receive orientation until [REDACTED].

Staff person E, whose first day of work was [REDACTED], did not receive orientation until [REDACTED].

Staff person F, whose first day of work was [REDACTED], did not receive orientation until [REDACTED].

Plan of Correction

Accepted [REDACTED] - 10/21/2025)

Plan of correction

Staff persons C, E, and F did receive the required general fire safety and emergency preparedness training on 4/17/2025.

An audit of all staff persons will be conducted by the Executive Director to ensure all have received the general fire safety and emergency preparedness training. This will be completed by 10/17/2025.

Education on 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 will be provided to the Executive Director by the HR department by 10/17/2025.

An audit of new hires will be conducted monthly starting 10/24/25 for 3 months by the Executive Director to ensure they have received orientation in general fire safety and emergency preparedness on their first day of work.

Administrator to develop a tracking system for all new hires to ensure they receive all required orientation training in accordance with 2600.65a.

- As part of the quality management review, all staff training will be audited to ensure all staff training is completed.

Licensee's Proposed Overall Completion Date: 10/24/2025

Implemented [REDACTED] - 11/05/2025)

65b - Rights/Abuse 40 Hours

5. 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, date of hire, [REDACTED], did not receive required orientation training until [REDACTED]

Staff person E, date of hire, [REDACTED], did not receive required orientation training until [REDACTED]

65b - Rights/Abuse 40 Hours (continued)

Staff person F, date of hire, [REDACTED] did not receive required orientation training until [REDACTED].

Plan of Correction

Accept [REDACTED] - 10/21/2025)

Plan of correction

Staff persons C, E, and F did receive the required orientation on 4/17/2025.

An audit of all staff persons will be conducted by the Executive Director to ensure all have received the orientation.

This will be completed by 10/17/2025.

Education on 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: will be provided to the Executive Director by the HR department by 10/17/2025.

An audit of new hires will be conducted monthly starting 10/24/25 for 3 months by the Executive Director to ensure they have received 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 within 40 scheduled working hours.

Administrator to develop a tracking system for all new hires to ensure they receive all required orientation training in accordance with 2600.65a.

- As part of the quality management review, all staff training will be audited to ensure all staff training is completed.

Licensee's Proposed Overall Completion Date: 10/24/2025

Implemented [REDACTED] - 11/05/2025)

65d - Initial Direct Care Training

6. 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 E was hired on [REDACTED] However, the staff person has not completed and passed the Department-approved direct care training course and passed the competency test.

Plan of Correction

Accept [REDACTED] - 10/21/2025)

Plan of correction

Staff person E will retake the Direct Care Staff Training and Competency Test, as [REDACTED] certificate is not available from Temple University since it was more than 3 years ago. This will be completed by 10/24/2025.

An audit of all staff persons will be conducted by the Executive Director to ensure all have received a copy of their certificate stating that they completed the Direct Care Staff Training and Competency Test. This will be completed by 10/17/2025.

Education on 65.d. Initial Direct Care Training will be provided to the Executive Director by the HR department by 10/17/2025.

An audit of new hires will be conducted monthly starting 10/24/2025 for 3 months by the Executive Director to ensure they have received a copy of their certificate stating that they completed the Direct Care Staff Training and Competency Test.

Administrator to develop a tracking system for all new hires to ensure they receive all required orientation training in accordance with 2600.65a.

65d - Initial Direct Care Training (continued)

- As part of the quality management review, all staff training will be audited to ensure all staff training is completed.

Licensee's Proposed Overall Completion Date: 10/24/2025

Implemented [REDACTED] - 11/05/2025)

65g - Annual Training Content**7. 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:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

Description of Violation

Staff persons C and F did not receive training in the following topics during training year [REDACTED] to [REDACTED]

- (1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
- (2) Emergency preparedness procedures and recognition and response to crises and emergency situations.

Plan of Correction

Accept [REDACTED] 10/21/2025)

Plan of correction

Staff persons C and F will receive training in (1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. (2) Emergency preparedness procedures and recognition and response to crises and emergency situations by 10/17/2025.

An audit of all staff persons will be conducted by the Executive Director to ensure all have received training in (1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. (2) Emergency preparedness procedures and recognition and response to crises and emergency situations. This will be completed by 10/17/2025.

Education on 65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas: will be provided to the Executive Director by the HR department by 10/17/2025.

Administrator to develop a staff training plan in accordance with 2600.66a to be reviewed as part of a regular quality management review, to ensure all staff receive required annual training in accordance with 2600.65g.

- As part of the quality management review, all staff training will be audited to ensure all annual staff training is completed.

Licensee's Proposed Overall Completion Date: 10/24/2025

Implemented [REDACTED] 11/05/2025)

85a - Sanitary Conditions**8. Requirements**

2600.

85a Sanitary Conditions (continued)

85.a. Sanitary conditions shall be maintained.

Description of Violation

On [redacted] at approximately 11:30 am, there were no individual towels, paper towels or other sanitary means to dry hands in the shared bathroom for bedrooms [redacted] and [redacted]

Plan of Correction

Accept [redacted] - 10/21/2025)

Plan of correction

Towels were provided to the shared bathrooms for rooms [redacted] and [redacted] on 9/17/2025. (see attached picture)

Towels have been provided to all bathrooms for rooms on the Memory Care Unit as of 9/17/2025.

Education on 85.a Sanitary conditions shall be maintained will be provided to the housekeeping staff by the Executive Director by 10/17/2025.

An audit of towels in the bathrooms on the Memory Care Unit will be conducted starting 10/24/25 and done monthly for 3 months by the Executive Director.

Housekeeping staff to monitor bathrooms at least once daily to ensure towels are available in the residents' bathrooms.

Licensee's Proposed Overall Completion Date: 10/24/2025

Implemented [redacted] 11/05/2025)

85d - Trash Receptacles

9. Requirements

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On [redacted] at 11:45 am, there was a large, uncovered, 50 gallon trash can in the common bathroom near the kitchen area in the Secure Dementia Care Unit (SDCU). The trash can was full of soiled briefs, paper placemats and other trash.

Plan of Correction

Accept [redacted] - 10/15/2025)

Plan of Correction

A cover was provided for the trash can on 9/17/2025. (see attached picture)

All trash cans were checked for covers on 9/29/2025.

Education on 85.d Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents will be provided to the housekeeping staff by the Executive Director by 10/17/2025.

An audit of trash cans will be conducted starting 10/24/25 and done monthly for 3 months by the Executive Director.

Licensee's Proposed Overall Completion Date: 10/24/2025

Implemented [redacted] - 11/05/2025)

103f - Refrigerator/Freezer Temps

10. Requirements

2600.

103f Refrigerator/Freezer Temps (continued)

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

Description of Violation

On [redacted] at 1:20 pm, the temperature in the ice cream freezer, in the main kitchen, was 11 degrees Fahrenheit.

Plan of Correction

Accept [redacted] - 10/21/2025)

Plan of correction

The ice cream freezer temperatures have been logged as under 10 degrees F for the month of September (see attached temp log).

Education on 103.f Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers will be provided to the dietary staff by the Executive Director by 10/17/2025.

Dietary staff will monitor temperatures in all freezers and refrigerators daily to ensure food is safely stored.

Licensee's Proposed Overall Completion Date: 10/24/2025

Implemented [redacted] - 11/05/2025)

132g - Fire Drills Days/Times

11. Requirements

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

According to staff schedules and staff interviews, the fewest number of staff present during a shift is 5, during the 11:00 pm to 7:00 am shift. The home has not conducted a fire drill during the 11:00 pm 7:00 am in the past year using only the minimum number of staff.

Plan of Correction

Accept [redacted] - 10/15/2025)

Plan of Correction

A fire drill will be conducted during the 11:00pm to 7:00 am shift using the minimum number of staff by 10/17/2025.

Education on 132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low on will be provided to the maintenance director by the Executive Director by 10/17/2025.

Licensee's Proposed Overall Completion Date: 10/17/2025

Implemented [redacted] - 11/05/2025)

141b2 - Medical Evaluation Changes

12. Requirements

2600.

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

141b2 - Medical Evaluation Changes (continued)

Description of Violation

Resident [redacted] medical evaluation, dated [redacted] does not indicate if the resident's needs can be safely met at the Personal Care Home OR if the resident is Nursing Facility Clinically Eligible (NFCE) with services to be provided at home or in a nursing facility.

Plan of Correction

Accept [redacted] - 10/15/2025)

Plan of correction

Resident #1's medical evaluation, dated 7/28/2025 was revised to indicate if the resident's needs can be safely met in at the Personal Care Home OR if the resident is Nursing Facility Clinically Eligible (NFCE) with services to be provided at home or in a nursing facility on (date). (see attached)

An audit of all medical evaluations will be conducted by the Director of Wellness to ensure there is indication if the resident's needs can be safely met at the Personal Care Home OR if the resident is Nursing Facility Clinically Eligible (NFCE) with services to be provided at home or in a nursing facility by 10/24/2025.

Education on 141.b.2. A resident shall have a medical evaluation: If the medical condition of the resident changes prior to the annual medical evaluation will be provided to the Director of Wellness by the Executive Director by 10/17/2025.

An audit of all new resident's medical evaluations will be conducted by the Director of Wellness starting 10/24/2025 for 3 months to ensure there is indication if the resident's needs can be safely met at the Personal Care Home OR if the resident is Nursing Facility Clinically Eligible (NFCE) with services to be provided at home or in a nursing facility.

Licensee's Proposed Overall Completion Date: 10/24/2025

Implemented [redacted] 11/05/2025)

225a - Assessment 15 Days

13. 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 [redacted] was admitted to the home on [redacted] however, [redacted] assessment was completed on [redacted].

Resident [redacted] assessment, dated [redacted], does not include [redacted] diagnosis of mild intellectual disability as documented on [redacted] medical evaluation dated [redacted].

Plan of Correction

Accept [redacted] 10/15/2025)

Plan of correction

Resident [redacted] assessment has been revised to include [redacted] diagnosis of mild intellectual disability as documented on [redacted] medical evaluation dated 1/27/2025. This was completed (date). (see attached)

An audit of all assessments will be conducted by the Director of Wellness to ensure timeliness and proper diagnoses by 10/24/2025.

Education on 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

225a - Assessment 15 Days (continued)

complete the initial assessment will be provided to the Director of Wellness by the Executive Director by 10/17/2025. An audit of all new resident's assessments will be conducted by the Director of Wellness starting 10/24/2025 for 3 months to ensure there is ensure timeliness and proper diagnoses.

Licensee's Proposed Overall Completion Date: 10/24/2025

Implemented () - 11/05/2025)

227a - Support Plan 30 Days

14. 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 () was admitted on (); however, the resident's initial support plan was not completed until ()

Plan of Correction

Accept () - 10/15/2025)

Plan of correction

Education on 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 will be provided to the Director of Wellness by the Executive Director by 10/17/2025. An audit of all new resident support plans will be conducted by the Director of Wellness starting 10/24/2025 for 3 months to ensure there is ensure timeliness.

Licensee's Proposed Overall Completion Date: 10/24/2025

Implemented () - 11/05/2025)

227h - Support Plan Refuse Sign

15. Requirements

2600.

227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident () participated in the development of () support plan on (). The resident did not sign the support plan. The home did not make a notation regarding the resident's inability, refusal or that () declined to sign the support plan.

Resident () participated in the development of () support plan on (). The resident did not sign the support plan. The home did not make a notation regarding the resident's inability, refusal or that () declined to sign the support plan.

Plan of Correction

Accept () - 10/15/2025)

Plan of correction

Education on 227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation

227h - Support Plan Refuse Sign (continued)

of inability or refusal to sign shall be documented will be provided to the Director of Wellness by the Executive Director by 10/17/2025.

An audit of all new resident support plans will be conducted by the Director of Wellness starting 10/24/2025 for 3 months to ensure there is notation regarding the resident's inability, refusal or that [REDACTED] declined to sign the support plan.

Licensee's Proposed Overall Completion Date: 10/24/2025

Implemented [REDACTED] - 11/05/2025)

231e - No Objection Statement

16. Requirements

2600.

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident [REDACTED] was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction

Accepted [REDACTED] 10/21/2025)

Plan of correction

Resident [REDACTED]'s designated person will be contacted to sign the record stating they have not objected to the admission by 10/17/2025.

An audit of resident's charts on the Memory Care Unit will be conducted by the Executive Director to ensure documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit by 10/24/2025.

Education on 231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit will be provided to the Executive Director by the HR department by 10/17/2025.

An audit of all new resident charts will be conducted by the Executive Director starting 10/24/2025 for 3 months to ensure there is documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

As part of the SDCU admission process, the administrator will ensure all new residents admitted to the SDCU have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Licensee's Proposed Overall Completion Date: 10/24/2025

Implemented [REDACTED] - 11/05/2025)

236 - Staff Training

17. Requirements

2600.

236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

236 - Staff Training (continued)

Description of Violation

Direct care staff person C, who works in the SDCU, had only 4.25 hours of training in dementia care during the [redacted] to [redacted] training year.

Plan of Correction

Accept [redacted] - 10/21/2025)

Plan of correction

Staff persons C will receive and additional 1.75 hours of dementia training by 10/17/2025.

An audit of all staff persons working on the Memory Care Unit will be conducted by the Executive Director to ensure all have received the dementia training of 6 hours. This will be completed by 10/24/2025.

Education on 236. Training – Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation) will be provided to Executive Director by the HR department by 10/17/2025.

An audit of new hires who work on the Memory Care Unit will be conducted monthly starting 10/24/25 for 3 months by the Executive Director to ensure they have received 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Administrator to develop a staff training plan in accordance with 2600.66a to be reviewed as part of a regular quality management review, to ensure all staff who work in the SDCU receive required annual training in accordance with 2600.236.

- As part of the quality management review, all staff training will be audited to ensure staff in the SDCU complete at least 6 additional hours of dementia training annually in accordance with 2600.236

Licensee's Proposed Overall Completion Date: 10/24/2025

Implemented [redacted] - 11/05/2025)