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

August 5, 2026

[redacted] ADMINISTRATOR
P.A.L., INC.
122 RIDGEVIEW STREET
YOUNGWOOD, PA, 15697

RE: RIDGEVIEW RESIDENTIAL CARE
122 RIDGEVIEW STREET
YOUNGWOOD, PA, 15697
LICENSE/COC#: 42858

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/02/2026 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: *RIDGEVIEW RESIDENTIAL CARE* **License #**: *42858* **License Expiration**: *11/06/2026*

Address: *122 RIDGEVIEW STREET, YOUNGWOOD, PA 15697*

County: *WESTMORELAND* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *P.A.L., INC.*

Address: *122 RIDGEVIEW STREET, YOUNGWOOD, PA, 15697*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *02/18/1999* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *33* **Waking Staff**: *25*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *04/02/2026*

Inspection Dates and Department Representative

04/02/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *40* **Residents Served**: *29*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *29*

Diagnosed with Mental Illness: *11*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *4*

Have Physical Disability: *0*

Inspections / Reviews

04/02/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/03/2026*

05/22/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/05/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/29/2026*

Inspections / Reviews *(continued)*

07/16/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/05/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/04/2026*

08/05/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/05/2026*

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

29a SOPb1- Hospice Care: Doctor Certification

1. Requirements

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:
1. A physician, who is not an employee or contractor of the home, has certified in writing that the resident is actively dying and may suffer bodily injury or a hastened death as a result of participation in a fire drill.

Description of Violation

Hospice resident #1, who was not evacuated during the fire drill conducted on 12/15/2025 through 3/8/2026, did not have a written certification from a physician that the resident is actively dying and may be injured or suffer a hastened death as the result of participating in a fire drill.

Plan of Correction ***Accept ([redacted] - 05/21/2026)***

Immediate action: inspector found documentation that bed-bound resident was not evacuated during the fire drill and no documentation from physician that resident was actively dying and may be injured or suffer a hastened death as a result of fire drill participation. Resident was deceased at time of inspection.

Corrective action: Administrator and Asst Administrator will ensure all residents, even bed-bound residents, are evacuated for all fire drills, unless the certified physician documents that the resident is actively dying or will suffer a hastened death as a result of fire drill participation.

Preventative action: If facility has a bed-bound resident, Administrator will keep constant communicate with physician about resident's status to determine if physician believes that resident is safe to participate in fire drills. If physician believes that resident's participation would cause undue harm to resident, Administrator will request this physician certification in writing and keep with fire drill logs and in resident file.

Licensee's Proposed Overall Completion Date: *05/11/2026*

Implemented ([redacted] - 08/05/2026)

81b - Resident Personal Equipment

4. Requirements

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

Description of Violation

The bedside enabler on resident #2's bed was not properly secured and was able to be moved approximately 4 inches to the left and 4 inches to the right.

The bedside enabler on resident #3's bed was not properly secured and was able to be moved approximately 4 inches to the left and 4 inches to the right.

The bedside enabler on resident #5's bed had an opening approximately 12 inches 16 inches, posing a potential

81b - Resident Personal Equipment (continued)

entrapment hazard. The enabler was not properly secured and was able to be moved approximately 4 inches to the left and 4 inches to the right.

Repeat violation 4/1/25

Plan of Correction ***Directed ([redacted] - 07/16/2026)***

Immediate action: The inspector found beside enabler that was not properly secured and a bedside enabler that had a large opening. This is a repeat violation.

Corrective action: Asst Administrator had hospice change out bed enabler for resident 2 and substitute for half bed rails.
Resident 3 also had bed enabler changed to half bed rails.
Resident 5 bed enabler was removed due to [redacted] not using it. Staff assist this resident into and out of bed.

Preventative action: Administrator and asst administrator will find a secure bed enabler that all families must purchase if resident requests a bed enabler to assist with bed mobility. Administrator and asst administrator will complete monthly bed audits beginning in May 2026 for 6 months. All new admissions will have a bed audit completed immediately on admission.

Directed:
By 7/30/26, the administrator will ensure resident #2 and resident #3's half bed rails meet FDA standards for hospital beds/bed rails, industry standards and best practices.
[redacted] 7/16/26

By 7/30/26, the administrator will ensure the secure bed enabler that all families must purchase if a resident requests a bed enabler to assist with bed mobility meets FDA standards for hospital beds/bed rails, industry standards and best practices.
[redacted] 7/16/26

Directed Completion Date: *07/30/2026*

Implemented ([redacted] - 08/05/2026)

82a - Poisonous Materials

5. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

At approximately 11:45 a.m., there was a clear plastic spray bottle with approximately 3 tablespoons of clear liquid located in the home's lower-level cleaning closet. However, the clear spray bottle did not contain the original manufacturer's label.

82a - Poisonous Materials *(continued)*

Plan of Correction ***Accept (- 07/16/2026)***

Immediate action: Inspector found spray bottle without appropriate label for liquid that was contained in the bottle.

Corrective action: Asst Administrator emptied the liquid from the spray bottle and disposed of the spray bottle.

Preventative action: Administrator and asst administrator will provide staff education of use of appropriate labels on all cleaning products. Housekeeper will be educated on applying appropriate labels. Poster will be hung at all cleaning chemical areas for staff reminders.

Proposed Overall Completion Date: 05/29/2026

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented (- 08/05/2026)

88a - Surfaces

6. 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

There was an approximate 6 inch x 6 inch hole in the plaster on the left side wall approximately 3 feet from the floor in bedroom #1.

Plan of Correction ***Directed (- 07/16/2026)***

Immediate action: The Inspector found a hole in resident bedroom wall that occurred as a result of recliner chair.

Corrective action: Asst Administrator patched hole in resident's wall

Preventative action: Administrator and asst administrator will apply a plastic guard on the wall of any resident that has a recliner close to the wall to prevent any holes on the wall.

Directed:
By 7/30/26 and monthly thereafter, the administrator or designee will monitor the floors, walls, ceilings, windows, doors and other surfaces in the home to ensure they are clean, in good repair and free of hazards. Documentation will be kept.

7/16/26

Directed Completion Date: *07/30/2026*

Implemented (- 08/05/2026)

101j7 - Lighting/Operable Lamp

7. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:

101j7 - Lighting/Operable Lamp *(continued)*

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident #2 does not have access to a source of light that can be turned on/off at bedside. The closest source of light was approximately 8 feet from the resident's bed.

Plan of Correction ***Accept (- 07/16/2026)***

Immediate action: Inspector found that resident 2 did not have a source of light near bed since family rearrange room.

Corrective action: Asst Administrator assembled an adhesive battery-operated light on the wall beside resident's bed.

Preventative action: Administrator educated family of regulation with light position. Administrator and asst administrator will perform monthly audits to ensure all residents have access to light near their bed.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented (- 08/05/2026)

103e - Left Overs

8. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

There were approximately 15 undated frozen chicken patties in a clear plastic zip lock bag in the white stand-up refrigerator in the home's upper-level main kitchen.

There were approximately 2 undated chicken parmesan patties in a clear plastic zip lock bag in the white stand-up refrigerator in the home's upper-level main kitchen.

Plan of Correction ***Accept (- 07/16/2026)***

Immediate action: Inspector found undated chicken patties in clear plastic bag in upper main kitchen fridge. Staff had taken patties out of freezer for the meal and forgot to date them.

Corrective action: Chicken patties were dated correctly.

Preventative action: Staff were educated/reminded about dating food even if pulled from freezer for that day's meal. Med techs to double check food in fridge each day for dates.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented (- 08/05/2026)

123c Evacuation Diagrams

9. Requirements

2600.
123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

The home currently serves 29 residents. The emergency evacuation diagram did not accurately reflect the current floor plan of the homes lower level. Multiple rooms had changed positions within the home, room number identifiers on resident rooms did not match indicators on diagram, and a majority of the rooms were mislabeled or misidentified on the diagram.

Plan of Correction ***Accept ([redacted] - 07/16/2026)***

Immediate action: Inspector found evacuation diagram did not accurately reflect current floor plan.

Corrective action: Asst Administrator updated evacuation diagram.

Preventative action: Administrator and asst administrator will update evacuation diagrams if any physical changes occur in the building.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented ([redacted] - 08/05/2026)

181c Self administration Assessment

10. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self administer and the need for medication reminders.

Description of Violation

At 10:45 a.m., there was a container of OTC Visine in the sink cabinet located in the semi-private resident bathroom belonging to residents #4 and #6. However, these residents have not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Plan of Correction ***Accept ([redacted] - 07/16/2026)***

Corrective action: Physician ordered refresh drops for resident 6. These drops are locked in med room. Family was informed that medications, regardless of OTC, cannot be brought in for residents by families. Families educated to inform staff if they determine new need for resident. Resident 4 chose to dispose of drops due to non-use. Resident 4 educated about regulation of all meds.

Corrective action: Asst Administrator requested physician order refresh eye drops for resident 6.

Preventative action: Resident 6 family educated about not bringing in OTC meds for resident. Resident 4 educated to request medications for needs that arise.

181c - Self-administration Assessment *(continued)*

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented ([redacted] - 08/05/2026)

183b - Meds and Syringes Locked

11. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 4/2/26, at 10:45 a.m., OTC medication, Visine was unlocked, unattended, and accessible in the sink cabinet located in the semi-private bathroom of residents #4 and #6.

Plan of Correction ***Directed ([redacted] - 07/16/2026)***

Immediate action: Inspector found Visine eye drops in 2 resident rooms that were brought in by resident families.

Corrective action: Asst Administrator requested physician order refresh eye drops for resident 6. Physician ordered refresh drops for resident 6. These drops are locked in med room. Family was informed that medications, regardless of OTC, cannot be brought in for residents by families. Families educated to inform staff if they determine new need for resident. Resident 4 chose to dispose of drops due to non-use. Resident 4 educated about regulation of all meds.

Preventative action: Resident 6 family educated about not bringing in OTC meds for resident. Resident 4 educated to request medications for needs that arise.

Directed:
By 7/30/36 and monthly thereafter, the administrator or designee will monitor all resident bedrooms to ensure all Prescription medications, OTC medications, CAM and syringes are kept in an area or container that is locked, including medications and syringes kept in the resident's room.
[redacted] 7/16/26

Directed Completion Date: *07/30/2026*

Implemented ([redacted] - 08/05/2026)

184a - Resident's Meds Labeled

12. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #7 was prescribed Lispro 100 unit/MML pen, Inject Sub-Q per Sliding scale, before meals as follows:

184a Resident's Meds Labeled (continued)

ORDERED:
** 151 180 2U*
** 181 200 4U*
** 201 250 6U*
** 251 300 8U*
** 301 350 10U*
** 351 400 12U*
** 401 450 14 U*
** 451 500 equals 16U, greater than 500 call MD*

However, the pharmacy label indicates the following:
LABEL:
** 151 180 2U*
** 181 200 4U*
** 201 250 6U*
** 251 300 8U*
** 301 350 10u*
** 351 400 12U*
** Greater than 400 call MD less than 70 use hypoglycemia protocol and call MD.*

Repeat violation 4/1/25

Plan of Correction ***Accept ([redacted] - 05/22/2026)***

Immediate action: Inspector found discrepancy with Lispro sliding scale for resident 7.

Corrective action: Asst administrator contacted pharmacy and corrected the sliding scale immediately after inspector found it.

Preventative action: Pharmacy will perform quarterly med audits. Asst administrator will monitor sliding scale for discrepancy monthly or PRN.

Licensee's Proposed Overall Completion Date: *05/11/2026*

Implemented ([redacted] - 08/05/2026)

185a - Implement Storage Procedures

13. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

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 #4 is prescribed Senna, 8.6 tablet, take one tablet every 24 hours as needed. On 4/2/26, the medication was not available in the home.

Plan of Correction ***Directed (- 07/16/2026)***

Immediate action: Inspector found resident 4 prescribed Senna, but Senna not in facility.

Corrective action: Asst administrator spoke with resident, who is [redacted] resident chose not to take Senna. Asst administrator requested discontinue order from physician, per resident request.

Preventative action: Pharmacy will perform quarterly med audits. Asst administrator and administrator will perform med audits monthly and PRN for new residents.

Directed:

By 7/30/26 and monthly thereafter, the administrator or designee will administrator and administrator will perform med audits monthly and PRN for new residents.

[redacted] ***7/16/26***

Directed Completion Date: *07/30/2026*

Implemented (- 08/05/2026)

190a - Completion Medication Course

14. Requirements

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person D, who has not successfully completed the Department-approved medications administration course annual practicum, administered medications to resident #1 to include the following:

** On 3/22/26, 8:30 a.m. - Losartan*

** On 3/22/26, 8:30 a.m. - Metoprolol*

Plan of Correction ***Directed (- 07/16/2026)***

Immediate action: Inspector found that staff person D had not completed Department-approved medication administration course annual practicum.

Corrective action: Asst administrator signed staff person D up for department-approved medication administration

190a - Completion Medication Course (continued)

course. Staff person completed course.

Preventative action: all medication administering staff to complete department-approved medication administration course annually before annual expiration date.

Directed:
By 7/30/26 and monthly thereafter, the administrator or designee will audit staff records for all staff who administer medication, to ensure they are qualified to administer medication. Documentation will be kept.
[redacted] ***7/16/26***

Directed Completion Date: *07/30/2026*

Implemented ([redacted] - 08/05/2026)

225c - Additional Assessment

15. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #3's assessment, dated [redacted], was not updated to address the resident's use of a bed cane and safety needs associated with the use of a bed cane and how this need would be met:
** The intended use and any risks associated with the use*
** The resident's ability to use the device safely for the purpose it was intended*
** Identification of the specific device to be used and whether a cover is required to meet FDA guideline*

Repeat violation 4/1/25

Plan of Correction ***Directed ([redacted] - 07/16/2026)***

Immediate action: Inspector found that resident 3 RASP was not updated to address bed cane use for safety needs.

Corrective action: Asst administrator contacted hospice to remove bed cane/enabler and add half side rails.

Preventative action: Asst administrator and administrator to perform bed audits monthly and as needed for new residents.

Directed:
By 7/301/26 and monthly thereafter, the administrator or designee will audit all resident assessments to ensure the assessment for any resident who utilizes a bed side mobility device indicates the flowing:
** The intended use and any risks associated with the use*
** The resident's ability to use the device safely for the purpose it was intended*
** Identification of the specific device to be used and whether a cover is required to meet FDA guideline*
Documentation will be kept.
[redacted] ***7/16/26***

225c Additional Assessment *(continued)*

Directed Completion Date: *07/30/2026*

Implemented ([redacted] - 08/05/2026)

227g -Support Plan Signatures

17. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #2's support plan, dated [redacted], was not signed by the resident nor does it indicate the resident was unable to participate, declined to participate, refused to sign or was unable to sign.

Plan of Correction ***Directed ([redacted] - 07/16/2026)***

Immediate action: Inspector found that resident 2 RASP unsigned by resident without appropriate documentation as to why unsigned.

Corrective action: Asst administrator requested resident sign RASP, but she declined signing. This was documented appropriately.

Preventative action: Asst administrator and administrator to double check all RASPs completed to ensure resident signed or it's documented as to why it's not signed.

Directed:
By 7/30/26 and monthly thereafter, the administrator or designee will audit all resident records to ensure an annual support plan is present, and signed by the resident or indicates the resident was unable to participate, declined to participate, refused to sign or was unable to sign. Documentation will be kept.
[redacted] ***7/16/26***

Directed Completion Date: *07/30/2026*

Implemented ([redacted] - 08/05/2026)