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

August 25, 2026

[redacted], OWNER
HEARTFUL HANDS LLC
[redacted]

RE: HEARTFUL HANDS LLC
514 MITCHELL AVENUE
CLAIRTON
CLARITON, PA, 15025
LICENSE/COC#: 45370

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/16/2026 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: *HEARTFUL HANDS LLC* **License #**: *45370* **License Expiration**: *02/14/2027*

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: *2* **Total Daily Staff**: *34* **Waking Staff**: *26*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *07/16/2026*

Inspection Dates and Department Representative

07/16/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *36* **Residents Served**: *30*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *30* **Are 60 Years of Age or Older**: *23*

Diagnosed with Mental Illness: *12* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *2* **Have Physical Disability**: *1*

Inspections / Reviews

07/16/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/03/2026*

08/04/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/21/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/07/2026*

Inspections / Reviews *(continued)*

08/10/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/21/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/22/2026*

08/25/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/21/2026*

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

20b8 - Quarterly Account

1. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
8. The home shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

Description of Violation

Resident #1 has not received a quarterly account of financial transactions in 2026.

Resident #2 has not received a quarterly account of financial transactions in 2026.

Plan of Correction ***Accept (- 08/04/2026)***

On 7/21/2026, both resident #1 and #2 expense reports were completed and issued to the residents.
Heartful Hands scheduled Huntington Bank to come onsite on 7/21/26 to meet with residents to open an account (if desired) that includes a debit card.
One time per week, a shuttle service will transport residents to and from the bank to handle financial matters. Staff will assist as requested but will ride with them.
On 7/21/2026, resident #2 opened an account and received a debit card to handle own expenses. Resident #1 requested that be in charge of finances.
Heartful Hands will offer to lock up residents' cards for safety.
As of 8/3, we are still waiting for the resident cards to arrive. Cash will no longer be held for Heartful Hands residents as a general practice.
On 8/3/2026, we created an expense-tracking sheet to track those who need a higher level of support and have limited resources.
Each resident will receive their balance sheets by the 5th business day following the end of the prior month. (Sheet has been uploaded).
Resident accounts of financial transactions will be audited by the administrator and/or designee in the September 2026 quarterly audit.

Both residents' reports are attached.

Licensee's Proposed Overall Completion Date: *08/10/2026*

Implemented (- 08/25/2026)

65a - FS Orientation 1st Day

3. 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.

65a - FS Orientation 1st Day *(continued)*

6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Ancillary staff person A hired [redacted], did not receive orientation on the following topics:

1. Evacuation procedures

2. Staff duties & responsibilities -fire drills

3. Designated meeting place outside/interior fire safe area

4. Smoking safety procedures/policy

5. Location & use of fire extinguishers

6. Smoke detectors & fire alarms

7. Telephone use and notification of emergency services

Plan of Correction ***Directed ([redacted] - 08/10/2026)***

Staff A was trained on all items that were checked, and the staff and new hire failed to sign the document. On 7/17/2026, these policies were reviewed, and the document was signed acknowledging orientation.

[redacted], on 7/18/2026, reviewed policies and procedures with [redacted] as ALL new hires are required to complete this training whether they will provide direct care or not.
This will be audited in quarterly audits starting in the next quarterly audit at the beginning of October 2026.

Proposed Overall Completion Date: 08/05/2026

DIRECTED
Within one day of receipt of the plan of correction: The administrator shall complete an audit of all newly hired direct staff persons records to ensure all staff persons have completed the required education in accordance with Regulation 2800.65(a). [redacted] 8/10/26

Directed Completion Date: *08/11/2026*

Implemented ([redacted] - 08/25/2026)

65b - Rights/Abuse 40 Hours

4. 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

Ancillary staff person A hired [redacted], did not receive training on any of the following topics:

1. Resident rights

2. Emergency medical plan

3. Mandatory reporting of abuse - OAPSA

65b - Rights/Abuse 40 Hours (continued)

4. Reporting reportable incidents and conditions

Plan of Correction ***Accept (- 08/10/2026)***

Staff A was trained on all items that were checked, and the staff and new hire failed to sign the document. On 7/17/2026, these policies were reviewed, and the document was signed acknowledging orientation of regulation 2600.65b.

[redacted] on 7/18/2026, reviewed policies and procedures with [redacted] as ALL new hires are required to complete this training whether they will provide direct care or not. This staff member was hired as a part-time cook. Effective immediately, an audit of all new staff files will be conducted by Administrator or designee by 8/18 to ensure all required education in accordance with Regulation 2800.65(b) is completed.

Licensee's Proposed Overall Completion Date: *08/18/2026*

Implemented (- 08/25/2026)

65f - Training Topics

5. 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.

Description of Violation

Direct care staff person B hired on [redacted], did not receive training or instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during the 1/1/25 – 12/31/25 staff training year.

Plan of Correction ***Directed (- 08/10/2026)***

Staff B retired on [redacted] and returned in [redacted] Heartful Hands was cited for this in 2025. Due to a new staff changeover and training implementation effective 7/28/2025, Heartful Hands has complied with the following Landmark schedule through [redacted] office on a monthly basis through the current date. Final date of employment is [redacted]
We will be in compliance with 2600.65.f. by ensuring all staff are in attend training according to the regulation. All training logs will be held in our staff training book. The Administrator/Designee will monitor this monthly, and auditing will start on 8/27/2026 and the last week of each month to ensure the monthly expectation has been met.

Proposed Overall Completion Date: 08/05/2026

DIRECTED
Within two days of receipt of the plan of correction: The administrator shall educate staff person B on Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan. Documentation of education of education shall be kept in accordance with Regulation 2600,65i, [redacted] 8/10/26

Directed Completion Date: *08/12/2026*

Implemented (- 08/25/2026)

65g - Annual Training Content

6. 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:
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102).

Description of Violation

Direct care staff person B hired on [redacted], did not receive training on the Older Adult Protective Services Act during the 1/1/25 – 12/31/25 staff training year.

Plan of Correction ***Directed ([redacted] - 08/10/2026)***

Staff B retired on [redacted] and returned in [redacted] Heartful Hands was cited for this in 2025. Due to a new staff changeover and training implementation effective 7/28/2025, Heartful Hands has complied with the following Landmark schedule through [redacted] office on a monthly basis through the current date. This employee's final date of employment is [redacted]

We will continue to be in compliance with 2600.65.f. by ensuring all staff are in attendance at monthly training according to our home training plan. All trainings with staff attendance are kept in our staff training book. The Administrator/Designee will monitor this monthly, and auditing will start on 8/27/2026 and the last week of each month to ensure the monthly expectation has been met.

Proposed Overall Completion Date: 08/27/2026

DIRECTED
Within two days of receipt of the plan of correction: The administrator shall educate staff person B on The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102). Documentation of education of education shall be kept in accordance with Regulation 2600,65i, [redacted] 8/10/26

Directed Completion Date: *08/12/2026*

Implemented ([redacted] - 08/25/2026)

88a Surfaces

7. 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 7/16/26 at approximately 10:46 a.m., the cold air return grill in bathroom #7 next to the toilet attached to the wall and above the cove base is rusty.

On 7/16/26 at approximately 10:58 a.m., the ceiling exhaust fan in bathroom #6 above the toilet area has dust matted on the grill vents and what appears to be possible dead insects or clumps of dust in the light fixture.

On 7/16/26 at approximately 11:31 a.m., the stainless-steel round metal plates for the shower floor drains were both unattached and had no way of being secured, which left the 2-inch drain hole exposed to the residents using the showers.

On 7/16/26 at approximately 11:32 a.m., in bathroom #3 in both shower stall areas the plaster and paint above both shower surrounds are peeling and coming off the walls.

88a - Surfaces *(continued)*

Plan of Correction ***Accept (- 08/10/2026)***

The facility manager will train all staff on August 17, 2026, regarding Regulation 2600.88.a.
This training will include education on the regulation itself, as well as the home's policies and procedures to maintain compliance. The training will be provided by the facility manager. This will be audited quarterly by the Administrator/Designee/Facility Manager.

Licensee's Proposed Overall Completion Date: *08/18/2026*

Implemented (- 08/25/2026)

93b - Railings

8. Requirements

2600.
93.b. Each porch must have a well-secured railing.

Description of Violation

On 7/16/26 at approximately 10:40 a.m., the wooden railings and deck landing leading from the second-floor emergency exit were unstable and rock back and forth approximately an inch and a half or more.

Plan of Correction ***Accept (- 08/10/2026)***

Our facility manager has contacted a contractor and has set up an appointment for the week of 8/10. Exit door on fire escape ramp has been closed off until work has been completed.

The facility manager will train all staff on August 17, 2026, regarding Regulation 2600.96.b. This training will include education on the regulation itself, as well as the home's policies and procedures to maintain compliance. The training will be provided by the facility manager. Documentation of this education will be maintained in accordance with Regulation 2600.65(i)

Heartful Hands has two alternative exits on the floor where this exit is being repaired.

The Facility Manager/Administrator Designee will include the fire escape in the weekly building audit and monitoring process. This documentation will be maintained in accordance with Regulation 2600.65(i) and log in our weekly administrative building check binder, this will include an audit of exits after each drill starting 8/21/26.

Licensee's Proposed Overall Completion Date: *08/21/2026*

Implemented (- 08/25/2026)

94b - Non-Skid Surface

9. Requirements

2600.
94.b. Interior stairs, exterior steps and ramps must have nonskid surfaces.

Description of Violation

On 7/16/26 at approximately 10:40 a.m., the 19 steps leading down from the 2nd floor outside deck only have a nonskid surface on ten of the steps.

94b - Non-Skid Surface *(continued)*

Plan of Correction ***Accept (- 08/10/2026)***

Our facility manager has contacted a contractor and has set up an appointment for the week of 8/10. The exit door on the fire escape ramp has been closed off until work has been completed.

The Facility Manager/Administrator Designee will include the fire escape in the weekly building audit and monitoring process. This documentation will be maintained in accordance with Regulation 2600.65(i) and stored in our weekly administrative building check binder, this will include an audit of exits after each drill starting 8/21/26.

Licensee's Proposed Overall Completion Date: *08/21/2026*

Implemented (- 08/25/2026)

100a - Exterior - Free of Hazards

10. Requirements

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

Description of Violation

On 7/16/26 at approximately 10:40 a.m., the 19 steps leading down from the 2nd floor outside deck are very unstable. The wooden stair treads are dry rotted and very spongy when walking down the steps. The wooden cleats that the stair treads are attached to are cracked and coming away from the wooden stringer.

On 7/16/26 at approximately 11:09 a.m., lying outside in the grass yard adjacent to the walkway leading to the metal exit door on the right side of the house there was a rusty barbecue grill and 3 filled black plastic garbage bags filled with linens.

On 7/16/26 at approximately 11:09 a.m., lying outside in the grass yard adjacent to the walkway leading to the metal exit door on the right side of the house there was a half open white cardboard box containing "Abtco" 8" inch wide by 12' foot long white horizontal vinyl siding.

Plan of Correction ***Accept (- 08/10/2026)***

On 7/19, all debris, which included the rusty barbecue grill, 3 black garbage bags filled with linen, and a white cardboard box containing "Abtco" vinyl siding, was removed by Facility Manager .

The facility manager will train all staff on August 17, 2026, regarding Regulation 2600.100.a. This training will include education on the regulation itself, as well as the home's policies and procedures to maintain compliance. The training will be provided by the facility manager. Documentation of this education will be maintained in accordance with Regulation.
The Facility Manager/Administrator Designee will include the fire escape in the weekly building audit and monitoring process. This documentation will be maintained in accordance with Regulation, logged in our administrative building check binder, and checked after every fire drill starting 8/21/2026.

Licensee's Proposed Overall Completion Date: *08/21/2026*

Implemented (- 08/25/2026)

132f - Alternate Exit Routes

11. Requirements

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

Description of Violation

The home's fire drill record indicated that only the living room, back door, side, and main exits were used for 4 consecutive fire drills conducted between 4/20/26 and 7/09/26.

Plan of Correction ***Accept ([redacted] - 08/10/2026)***

Effective August 2026, we will follow DHS's suggestion and not use all exits during monthly fire drills to ensure that staff and residents have experience in the event of a fire; we have practiced limited exits.

We will use alternative exit routes, but narrow them down. Instead of always using the living room, back door, side, and main exits, we will use 2 of the exits and alternate between them.
Every drill, we will continue to alternate to ensure compliance; this will include both night and daytime drills.

This will be documented in the fire drill log by 8/18/2026 to ensure compliance is documented. A staff training memo will be distributed notifying staff of expectations during fire drills and all other corrections by 8/7/2026.

On 8/19/2026, the administrator/designee will conduct a fire drill record review to ensure the alternative fire drill plan was executed. The log will be audited after the drill and inspection of all exits to ensure compliance with the correction.

Licensee's Proposed Overall Completion Date: *08/19/2026*

Implemented ([redacted] - 08/25/2026)

141a - Medical Evaluation

12. Requirements

2600.
141.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.

Description of Violation

Resident #3's initial medical evaluation, dated [redacted], does not include the following medical professional information:

- *The information on this form, the addendum sheet, and any attached list of medications was generated based on my evaluation.*
- *The above-named resident requires assistance or supervision with Activities of Daily Living, Instrumental Activities of Daily Living, or both, as defined by 55 PA, Code Chapter 2600.*

These sections were left blank.

Resident #4's initial medical evaluation, dated [redacted], does not include the following medical professional information:
The information on this form, the addendum sheet, and any attached list of medications was generated based on my evaluation.
The above-named resident requires assistance or supervision with Activities of Daily Living, Instrumental Activities

141a - Medical Evaluation (continued)

of Daily Living, or both, as defined by 55 PA, Code Chapter 2600.
These sections were left blank.

Plan of Correction ***Directed (- 08/10/2026)***

This happened during the Administrator transition due to noncompliance in July 2025.
Resident #3
On`7/17/2026 the medical evaluation included the following required statement:
This will be audited quarterly to ensure compliance is maintained and staff memo/training notifications will be distributed 8/17/2026

Resident #4
On 7/17/2026 the medical evaluation was completed and the client file was audited.

This will be audited quarterly by the Administrator/Designee starting the first week of October 2026. Training and compliance will be maintained, and a staff memo/training will be completed by the Administrator/Designee and distributed on 8/17/2026.

Proposed Overall Completion Date: 08/17/2026

DIRECTED
Within one day of the receipt of the plan of correction: The administrator shall audit all newly completed medical evaluations to ensure timeliness, completeness, and accuracy. 8/10/26

Directed Completion Date: *08/17/2026*

Implemented (- 08/25/2026)

141b1 - Annual Medical Evaluation

13. Requirements

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

Description of Violation

Resident #5's current medical evaluation is dated however, the prior medical evaluation is dated

Resident #5's medical evaluation, dated , medical profession Information does not include:
I am a physician, physician assistant, or certified nurse practitioner whose license to practice is in good standing.
The information on this form, the addendum sheet, and any attached list of medications was generated based on my evaluation.
The above-named resident requires assistance or supervision with Activities of Daily Living, Instrumental Activities of Daily Living, or both, as defined by 55 PA, Code Chapter 2600.
These sections were left blank.

Resident #6's medical evaluation, dated does not include the following medical professional information:
The information on this form, the addendum sheet, and any attached list of medications was generated based on my evaluation.
The above-named resident requires assistance or supervision with Activities of Daily Living, Instrumental Activities

141b1 Annual Medical Evaluation (continued)

of Daily Living, or both, as defined by 55 PA, Code Chapter 2600.
These sections were left blank.

Plan of Correction ***Directed (- 08/10/2026)***

This correction was a part of a previous correction in July of 2025. For Resident 5. On 7/17/2026, team conducted the medical evaluation. Heartful Hands and an updated DME was completed.
For Resident 6. Heartful Hands completed a DME, and the file was audited on 7/17/26.

Staff will be trained and educated on the regulation by 8/17/2026 by the administrator/designee. We will also monitor compliance in our quarterly audits; the next one is the first week in October 2026.

Proposed Overall Completion Date: 08/18/2026

DIRECTED
Within one day of the receipt of the plan of correction: The administrator shall audit all newly completed medical evaluations to ensure timeliness, completeness, and accuracy. 8/10/26

Directed Completion Date: *08/18/2026*

Implemented (- 08/25/2026)

225a - Assessment 15 Days

14. 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 #3's medical evaluation, dated included numerous diagnoses that were not included in the resident's initial assessment, dated to include cholesterol, inflammation, insomnia, vitamin deficiency, and Paranoid Schizophrenia.

Resident #4 was admitted to the home on however, the resident's initial assessment was not completed until .

Resident #4 medical evaluation, dated , included numerous diagnoses that were not included in the resident's assessment, dated to include depression, HTN, heart, cholesterol, potassium, swelling, COPD, vitamin deficiency, and pain SOB.

Resident #4's initial assessment does not include a Summary and Determination it only indicates "N/A" in this section.

Plan of Correction ***Directed (- 08/10/2026)***

This was a previous correction in 2025. This was part of the completed audit and corrections.

Resident #3 Medical Evaluation will be finalized by 8/7/26.
Resident #4: On 7/17/2026, a DME was completed to ensure all diagnoses are accurately reflected. On 7/23/26 a new RASP was completed.

225a - Assessment 15 Days (continued)

The home did not ensure that a written initial assessment was completed on the Department's assessment form within 15 days of the resident's admission.
Starting 7/17/26, the facility reviewed the files in corrections and noted the corrections assessment form.
The facility has retrained on the admission checklist, which includes completing the Department's initial assessment within 15 days of admission. The Administrator or designee will monitor all new admissions to ensure assessments are completed within the required timeframe.

Staff responsible for the admission process were retrained on the requirements of 55 Pa. Code §2600.225(a), including the use of the Department's assessment form and required completion timelines on 7/18/2026.

Effective immediately, Administrator/Designee will conduct quarterly audits of new admissions to verify that all initial assessments are completed accurately and within 15 days of admission. Any identified deficiencies will be corrected promptly, and additional staff training will be provided as needed. Staff will be trained again on the requirements of 55 Pa. Code §2600.225(a on 8/17/2026.

Proposed Overall Completion Date: 08/18/2026

DIRECTED
Within one day of the receipt of the plan of correction: The administrator shall audit all newly completed assessments to ensure timeliness, completeness, and accuracy. [redacted] *8/10/26*

Directed Completion Date: *08/18/2026*

Implemented ([redacted] ***- 08/25/2026)***

225c - Additional Assessment

15. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

Description of Violation

Resident #5's medical evaluation, dated [redacted] *includes diagnoses of Extrapyramidal and movements; however, these diagnoses are not included on the assessment dated* [redacted]

Resident #6's medical evaluation, dated [redacted]*, includes numerous diagnoses that are not included in the resident's assessment, dated* [redacted] *to include intellectual disability, seizures/mood, tremors, insomnia and vitamin deficiency.*

Plan of Correction ***Accept (*** [redacted] ***- 08/04/2026)***

Heartful Hands had changed administrators in late July 2026. The previous Administrator completed the assessment.
Resident #5:
On 7/17/2026, a new DME was completed with up-to-date, accurate information.

For Resident #6:
On 7/17/2026, a DME was completed to include accurate and updated information. We began electronic input in Tabula Pro and believe some information did not save properly.
Effective immediately, the medtech supervisor will notify the administrator/designee of medical changes and

225c Additional Assessment (continued)

ensure an updated RASP/DME is completed within 5 days of a significant change.
This will be audited quarterly to ensure compliance is maintained and staff memo/training notifications will be distributed on 8/18/2026

Licensee's Proposed Overall Completion Date: *08/18/2026*

Implemented ([redacted] - 08/25/2026)