pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **PRESBYTERIAN SENIOR CARE INC**
LEGAL ENTITY

To operate **SOUTHMINSTER PLACE**
NAME OF FACILITY OR AGENCY

Located at **880 SOUTH MAIN STREET, WASHINGTON, PA 15301**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **90**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **May 8, 2026** until **May 8, 2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **415930**

ISSUING OFFICER

Juliet Marsala
DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 04/23

Pennsylvania
Department of Human Services

Emailing Date: May 8, 2026

[redacted]
Presbyterian Senior Care Inc.
[redacted]

RE: Southminster Place
License #: 415930

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on March 2, 2026 and March 4, 2026, and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

Facility Information

Name: *SOUTHMINSTER PLACE* **License #**: *41593* **License Expiration**: *06/12/2026*

Address: *880 SOUTH MAIN STREET, WASHINGTON, PA 15301*

County: *WASHINGTON* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *PRESBYTERIAN SENIOR CARE INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I 2* **Date**: *04/11/2002* **Issued By**: *Township of South Strabane*

Staffing Hours

Resident Support Staff: *63* **Total Daily Staff**: *136* **Waking Staff**: *102*

Inspection Information

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

Reason: *Renewal, Provisional* **Exit Conference Date**: *03/04/2026*

Inspection Dates and Department Representative

03/02/2026 On Site: [redacted]

03/04/2026 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *90* **Residents Served**: *63*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *63*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *10* **Have Physical Disability**: *0*

Inspections / Reviews

03/02/2026 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *03/21/2026*

03/20/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/07/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *03/26/2026*

03/25/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/07/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/07/2026*

04/08/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/07/2026*

Reviewer: [redacted] **Follow Up Type:** *Exception*

25b - Contract Signatures

1. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident [redacted] resident-home contract, dated [redacted], is not signed by the resident.

Plan of Correction ***Accept [redacted] 03/20/2026)***

Upon notification of the deficiency regarding the resident signature missing, the Administrator informed the Marketing Coordinator that the contract was missing the resident's signature and had been marked as "refused to sign." The Administrator then asked that the resident be asked to sign the contract to bring it into compliance. The resident signed the contract on 3/4/2026.
To prevent recurrence, the Administrator provided education to the Marketing Coordinator, 3/4/2026 on the components of 2600.25.b. as well as the "Regulatory Issues and Frequently Occurring Situations" section of the RCG for 2600.25(a)(1)-(h).
Effective 3/12/2026, a whole-house audit will be completed to ensure compliance. Any issues will be corrected at the time of identification, with a completion date of 3/20/2026.
Moving forward, the Administrator will not sign off on new admission contracts until the resident's signature is present. This will allow the Administrator to audit each admission contract moving forward.
Results/findings of the audits will be brought to the home's next QM meetings for discussion, review, and suggestions for continuous improvement. The home's next QM meeting is scheduled for April 7, 2026.

Proposed Overall Completion Date: 03/20/2026

Licensee's Proposed Overall Completion Date: *04/07/2026*

Implemented [redacted] - 04/08/2026)

103f - Refrigerator/Freezer Temps

2. Requirements

2600.
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 approximately 1:45pm, there was no operable thermometer present in the main kitchen freezer.

Plan of Correction ***Accept [redacted] - 03/20/2026)***

Upon identification of the thermometer located in the main kitchen freezer not functioning correctly, the Dining Services Manager immediately replaced the broken thermometer with a new and functioning thermometer. That newly placed thermometer immediately dropped to the appropriate temperature required for freezers.
All other areas requiring thermometers were checked by the Dining Services Manager on 3/2/2026 to ensure proper placement and functioning of the thermometers.
To prevent recurrence, beginning 3/13/2026, the dining services team will be educated on the components of 2600.103f., with a completion date of 3/20/2026. Audits of applicable freezers and coolers will be completed daily x5 effective 3/16/2026, followed by weekly x 4, then monthly x 3, with the responsible party being the Dining Services Manager.

103f - Refrigerator/Freezer Temps (continued)

Results/findings of the audits will be brought to the home's next QM meetings for discussion, review, and suggestions for continuous improvement. The home's next QM meeting is scheduled for April 7, 2026.

Proposed Overall Completion Date: 03/20/2026

Licensee's Proposed Overall Completion Date: *04/07/2026*

Implemented [redacted] - 04/08/2026)

132g - Fire Drills Days/Times

3. 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

The home conducted the sleeping hour fire drills during the 4:00am hour on the following dates/times:

- [redacted] *at 4:00am*
- [redacted] *at 4:20am*
- [redacted] *at 4:30am*

.

Plan of Correction ***Accept [redacted] - 03/25/2026)***

Upon notification of the deficient practice on March 4, 2026, the Administrator reached out to the maintenance technician for the community to discuss the deficiency. A meeting was scheduled for the following day, where education was provided by the Administrator to both the maintenance technician for the community as well as the Building Services Director for the campus. The education was completed on March 5, 2026 and specifically focused on the night time drills as that was where the pattern developed over time. Documentation of the education will be kept in the POC binder located in the Administrator's office.
To break the existing pattern on night shift, an overnight fire drill was scheduled by the maintenance tech for 3/20/2026, somewhere around midnight. The maintenance tech and Administrator are the only staff aware of the scheduled date/time for the additional drill for the plan of correction.
In order to prevent recurrence, the Administrator will audit all fire drills on a monthly basis ongoing, beginning with the 3/20/2026 fire drill, to review compliance with the components of 2600.132, specifically auditing that no patterns exist.
Results/findings of the audits will be brought to the home's next QM meetings for discussion, review, and suggestions for continuous improvement. The home's next QM meeting is scheduled for April 7, 2026. Documentation of the home's QM meetings will be kept in the survey binder located within the Administrator's office.

Licensee's Proposed Overall Completion Date: *04/07/2026*

Implemented [redacted] - 04/08/2026)

144c1 - Smoking Area Guidelines

4. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

On [redacted] at approximately 11:00am, there was no fireproof receptacle or ashtray present in the home's designated smoking area, located on the eastern side of the building.

Plan of Correction ***Accept [redacted] - 03/25/2026)***

Upon notification of the deficient practice on 3/2/2026, the Administrator began to investigate the concern to better understand what unfolded. It was identified that the resident was not smoking in the designated smoking spot. There were a stainless-steel container and chair located in the courtyard for the resident to use, but the resident elected to smoke in a different location on the side of the building. The investigation also revealed that the staff had not consistently communicated to the resident where [redacted] needed to be when smoking so it wasn't solely a compliance issue on the resident's behalf.
To prevent recurrence, on the evening of 3/2/2026, a larger smoking receptacle was borrowed from a sister community until the replacement that had been ordered arrived. The new Commercial Smoking Receptacle was delivered 3/12/2026 and placed in the designated smoking area. This larger receptacle cannot be moved in the same way that the small stainless-steel receptacle was able to be moved. The Administrator met directly with the resident on the evening of 3/4/2026 to educate [redacted] on the regulatory guidelines and confirm that [redacted] understands the designated space and process moving forward. In addition, as the resident's cigarettes and lighter are kept locked in the nursing station, the nursing team was instructed, by the Administrator on 3/4/2026, to monitor the resident's smoking periods to ensure that [redacted] is utilizing the appropriate designated space provided appropriately.

Beginning 3/13/2026, the Administrator will educate nursing, activities, and maintenance team members on the components of 2600.144.c.1. with a completion date of 3/20/2026. Documentation of the staff education will be kept in the POC binder located within the Administrator's office.

To monitor ongoing compliance, beginning 3/16/2026, the administrator will perform random audits of the designated smoking area for compliance with the components of 2600.144 daily x5, followed by weekly x 4, then monthly x 3. Staff will continue to monitor that the resident is using the appropriate designated smoking area at the time of providing the resident with [redacted] cigarettes and lighter.

Results/findings of the audits will be brought to the home's next QM meetings for discussion, review, and suggestions for continuous improvement. The home's next QM meeting is scheduled for April 7, 2026. Documentation of the home's QM meetings will be kept in the survey binder located within the Administrator's office.

Proposed Overall Completion Date: 04/07/2026

Licensee's Proposed Overall Completion Date: *04/07/2026*

Implemented [redacted] - 04/08/2026)

183b - Meds and Syringes Locked

5. 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 [redacted] at approximately 11:15am, there were numerous unlocked, unattended and accessible medications in resident [redacted]s bathroom, to include the following:

- *Top Care nighttime cold and flu relief*
- *A 3 ounce tube of Icy Hot pain relief cream*
- *2 boxes of [redacted]*
- *2 boxes of [redacted]*
- *(2) 50 gram tubes of [redacted]*
- *1 bottle of [redacted]*

According to resident [redacted]s most recent assessment, dated [redacted], resident [redacted] is unable to self-administer medications.

REPEAT VIOLATION: [redacted], et. al.

Plan of Correction *Accept [redacted] - 03/25/2026)*

Upon notification of the deficiency, it was noted that the resident in question is alert and oriented as well as capable of self-administration of medications but had not requested to self-administer any of [redacted] existing orders. The RN Supervisor reached out to the resident's physician on 3/2/2026 to request an order for the self-administration of:
Top Care nighttime cold and flu relief
A 3-ounce tube of Icy Hot pain relief cream
2 boxes of [redacted]
2 boxes of [redacted]
(2) 50-gram tubes of [redacted]
1 bottle of [redacted]
The primary care physician was agreeable for the self-administration of the above OTC's and gave the order on 3/2/2026. The Resident Services Director completed the home's self-administration policy and procedure form for the resident to sign. The resident signed on 3/3/2026. The Resident Services Director updated the current RASP to reflect the resident's capability of self-administering medications.

Resident [redacted] resides in a private apartment with the option of locking the apartment doors, but resident [redacted] preferred the lock box option, therefore the home provided Resident [redacted] with a lockbox to secure the OTC medications.

To prevent recurrence, beginning 3/13/2026, the Resident Services Director will educate nursing staff on the components of 2600.183b, with a completion date of 3/20/2026. Documentation of the staff education will be kept in the POC binder located within the Administrator's office.

The Administrator sent a resident and family communication explaining the significance of supporting compliance with the components of 2600.183b on 3/17/2026. In addition, the topic was discussed in Resident Council on 3/18/2026. The topic will also be shared at the Family Council Meeting scheduled for 4/8/2026. Finally, to support

183b - Meds and Syringes Locked (continued)

compliance right from the time of admission, the Administrator created an addendum to be signed by the resident and responsible party, acknowledging education on the components of 2600.183b as well as an attestation to assist with compliance by following the guidelines.

Beginning 3/5/26, the Resident Services Director/Designee will complete a whole-house audit of resident rooms for compliance with the above regulation. Any issues will be corrected at the time of identification, with a completion date of 3/20/2026.

To monitor ongoing compliance, beginning the week of 3/23/2026, random audits of 5 resident apartments will follow the whole-house audit weekly x 4, then monthly x 3, with the responsible party being the Resident Services Director/designee.

Results/findings of the audits will be brought to the home's next QM meetings for discussion, review, and suggestions for continuous improvement. The home's next QM meeting is scheduled for April 7, 2026. Documentation of the home's QM meetings will be kept in the survey binder located within the Administrator's office.

Licensee's Proposed Overall Completion Date: *04/07/2026*

Implemented [redacted] - 04/08/2026)

251b - Record Entries Legible

6. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction tape was present on the name section of resident [redacted]s most recent medical evaluation, dated [redacted]

Plan of Correction ***Accept[redacted] 03/25/2026)***

Upon notification of the deficiency, the Resident Services Coordinator took immediate action on 3/4/2026 by completing a new copy of the medical evaluation from 6/5/2025 to be presented to the resident's primary care physician, who also happens to serve as the medical director for the campus, thus bringing the DME into compliance.
To enhance currently compliant operations, beginning 3/5/2026, the Resident Services Director began a whole-house audit of resident charts to ensure compliance with the components of 2600.251.b., with a completion date of 3/13/2026.
Additionally, the Resident Services Coordinator will provide education to the nurses in regard to 2600.251.b., specifically noting that correction tape or white out is not allowed to be utilized on a resident record at any time, with a completion date of 3/20/2026. Documentation of the staff education will be kept in the POC binder located in the Administrator's office.
Effective 4/1/2026, to maintain ongoing compliance, the Resident Services Director will complete monthly chart audits on residents admitted in the prior month as well as yearly updates due for completion in that same month, ensuring compliance with the components of this regulation. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Results/findings of the audits will be brought to the home's next QM meetings for discussion, review, and suggestions for continuous improvement. The home's next QM meeting is scheduled for April 7, 2026. Documentation of the home's QM meetings will be kept in the survey binder located within the Administrator's office.

251b - Record Entries Legible *(continued)*

Licensee's Proposed Overall Completion Date: *04/07/2026*

Implemented [redacted] - 04/08/2026)