





**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

Emailing Date: APRIL 28, 2025

[REDACTED]  
EC OPCO LAKEMONT FARMS LLC  
[REDACTED]

RE: CELEBRATION VILLA OF LAKEMONT FARMS  
3275 WASHINGTON PIKE  
BRIDGEVILLE, PA, 15017  
LICENSE/CO(#: 45081

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on 2/19/2025, 2/20/2025, and 4/21/25 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,

A handwritten signature in black ink that reads "Juliet Marsala".

Juliet Marsala  
Deputy Secretary  
Office of Long-term Living

Enclosure  
Licensing Inspection Summary

cc: [REDACTED]

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

April 25, 2025

[REDACTED]  
EC OPCO LAKEMONT FARMS LLC  
[REDACTED]  
[REDACTED]

RE: CELEBRATION VILLA OF LAKEMONT  
FARMS  
3275 WASHINGTON PIKE  
BRIDGEVILLE, PA, 15017  
LICENSE/COC#: 45081

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/19/2025, 02/20/2025 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: CELEBRATION VILLA OF LAKEMONT FARMS License #: 45081 License Expiration: 05/05/2025
Address: 3275 WASHINGTON PIKE, BRIDGEVILLE, PA 15017
County: ALLEGHENY Region: WESTERN

Administrator

Name: [Redacted]

Legal Entity

Name: EC OPCO LAKEMONT FARMS LLC
Address: [Redacted]
Phone: [Redacted]

Certificate(s) of Occupancy

Type: C-2 LP Date: 03/17/1999 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 109 Waking Staff: 82

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
Reason: Complaint, Provisional, Incident Exit Conference Date: 02/20/2025

Inspection Dates and Department Representative

02/19/2025 - On-Site: [Redacted]
02/20/2025 - On-Site: [Redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 140 Residents Served: 70

Secured Dementia Care Unit

In Home: Yes Area: Along the Journey Capacity: 30 Residents Served: 18

Hospice

Current Residents: 12

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 70
Diagnosed with Mental Illness: 1 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 39 Have Physical Disability: 0

Inspections / Reviews

02/19/2025 - Full

Lead Inspector: [Redacted] Follow-Up Type: POC Submission Follow-Up Date: 03/10/2025

03/11/2025 - POC Submission

Submitted By: [Redacted] Date Submitted: 03/31/2025
Reviewer: [Redacted] Follow-Up Type: POC Submission Follow-Up Date: 03/16/2025

Inspections / Reviews (*continued*)

## 03/14/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: 03/31/2025

Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 03/31/2025

## 04/25/2025 - Document Submission

Submitted By: [REDACTED] Date Submitted: 03/31/2025

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

In accordance with the Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/2016, "An approved carbon monoxide alarm at a care facility shall be installed in close proximity of, but not less than 15 feet from, any fossil fuel-burning device or appliance." However, on 2/19/25 at approximately 3:45 p.m., the carbon monoxide detector located outside of the home's boiler room was located approximately ten feet from the gas operated Infiniti Tankless hot water system.

REPEAT VIOLATION 4/25/24 et. al.

Plan of Correction

Accept (█ - 03/11/2025)

ACTION: On 2/19/25, the day of inspection, the home's maintenance staff relocated the carbon monoxide detector which is now 15 feet from the boiler room.

The detector is now labeled with the 15' distance requirement.

TRAINING: The Executive Director reviewed regulation 2600.18 with the Maintenance Director and Maintenance Assistant on 3/10/25. Documentation of the staff training shall be kept in accordance with 2600.65i.

ONGOING:

Any additional carbon monoxide detectors must have their location approved by both the maintenance director and the administrator prior to installation. Beginning week of 3/10/25 a member of the leadership team will walk the community weekly for the next 30 days to ensure carbon monoxide is properly placed and operational

Licensee's Proposed Overall Completion Date: 03/10/2025

Implemented (█ - 04/25/2025)

65f - Training Topics

3. Requirements

2600.

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

- 7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A, hired █ 23, did not receive annual training in required topics for the 2024 training year to include:

(7) Care for residents with mental illness or mental retardation, or both, if the population is served in the home.

Direct care staff person B, hired █ 23, did not receive annual training in required topics for the 2024 training year to include:

(7) Care for residents with mental illness or mental retardation, or both, if the population is served in the home.

65f - Training Topics (continued)

**Plan of Correction**

**Accept** [redacted] 03/11/2025)

*ACTION: All staff in the home have been assigned mental health training during inspection, this training will be completed by 3/31/25. Staff person A and B completed their training 3/10/2025.*

*TRAINING: For this training year, all staff have a completion deadline of March 31, 2025. A record of this training will be kept on each employee's Relias transcript and in the employee's file.*

*ONGOING: Moving forward training that meets the requirements for regulation 2600.65.f will be a part of the annual training plan for all staff.*

*On a monthly basis starting March 25, 2025, as part of the home's monthly Quality Assurance meeting agenda, the Administrative Assistant or Executive Director will review all training records for compliance and completion. A report of the findings will be included in the home's QA report. Any necessary follow-up actions will be planned at the time of QA review.*

**Licensee's Proposed Overall Completion Date: 03/31/2025**

**Implemented** [redacted] 04/25/2025)

85a - Sanitary Conditions

**4. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

**Description of Violation**

*On 2/19/25 at approximately 12:16 p.m., the floor of the private bathroom of resident room [redacted] belonging to resident #2 had various bits of unidentifiable debris, pieces of toilet paper, and sanitation wipes on the floor. Additionally, the resident's waste basket was stored in the shower stall and there were multiple small brown bits of an unidentifiable substance of unknown origin scattered on the floor of the shower stall.*

*On 2/19/25 at approximately 2:52 p.m., the freezer portion of combination General Electric refrigerator and freezer located in the kitchenette of the Along the Journey secured dementia care unit had unidentifiable bits of brown material scattered across the surface of the freezer, what appeared to be strands of human hair, and spatters of brown and red liquids of unknown origin.*

**Plan of Correction**

**Accept** [redacted] 03/11/2025)

*ACTION: Immediately after inspection on 2/19/25 the home's housekeeping staff cleaned the bathroom in resident room [redacted] removing all trash, sanitizing surfaces and storing items properly. Additionally, the freezer in the SDCU was cleared of any debris and trash and thoroughly cleaned after.*

*TRAINING: All Direct Care and housekeeping staff will be trained by March 14, 2025, on regulation 2600.85a. Staff postings were put in place on 2/24/25 to reiterate the expectations in resident rooms and with refrigerator maintenance/cleaning. Documentation of the staff training shall be kept in accordance with 2600.65i.*

*ONGOING: On 2/24/25 the home's management staff which includes the Executive Director, Maintenance Director, Director of Dining Services, Memory Care Coordinator, Resident Care Coordinator, Life Enrichment Director and Sales Director, started resident room and refrigerator audits. These audits are conducted a minimum of 3 times weekly for the next 30 days to ensure compliance with regulation 2600.85a. A record of these audits will be kept in the administrator's office.*

*As part of the home's next monthly March 25th, 2025, Quality Assurance Meeting a review of these audits will be conducted.*

**Licensee's Proposed Overall Completion Date: 03/10/2025**

85a - Sanitary Conditions (continued)

Implemented [REDACTED] 04/25/2025)

89b - Hot Water Temperature

5. Requirements

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 2/19/25 at approximately 11:37 a.m. the water temperature at the sink in the second-floor hallway half bathroom measured 128.1 degrees Fahrenheit. The water temperature was measured again on 2/20/25 at 9:20 a.m. and indicated 113.7 degrees Fahrenheit.

On 2/19/25 at approximately 11:52 a.m. the water temperature at the sink in the second-floor kitchenette across from resident room #212 measured 128.8 degrees Fahrenheit. The water temperature was measured again on 2/20/25 at 9:23 a.m. and indicated 114 degrees Fahrenheit.

On 2/19/25 at approximately 12:03 p.m. the water temperature at the sink in the private bathroom of resident room #220 belonging to resident #3 measured 130.1 degrees Fahrenheit. The water temperature was measured again on 2/20/25 at 9:26 a.m. and indicated 116.4 degrees Fahrenheit.

On 2/19/25 at approximately 12:03 p.m. the water temperature at the sink in the private bathroom of resident room #243 belonging to resident #2 measured 129.2 degrees Fahrenheit. The water temperature was measured again on 2/20/25 at 9:26 a.m. and indicated 115.7 degrees Fahrenheit.

On 2/19/25 at approximately 12:38 p.m. the water temperature at the sink in the private bathroom of resident room #227 belonging to resident #4 measured 131.7 degrees Fahrenheit. The water temperature was measured again on 2/20/25 at 9:30 a.m. and indicated 115.5 degrees Fahrenheit.

Plan of Correction

Accept [REDACTED] - 03/11/2025)

ACTION: Immediately after inspection, the home's Maintenance Director adjusted the central water temperature. During the second check the following day, all temperatures were within range as outlined in the LIS.

TRAINING: The Maintenance Director and Maintenance Assistant were trained on regulation 2600.89.b by the Executive Director on 2/24/25. Documentation of the staff training shall be kept in accordance with 2600.65i.

ONGOING: Water temperatures are being checked in 5 different areas of the building weekly for the next 30 days to ensure on-going compliance, documentation shall be kept in the administrator's office and will be reviewed at the home's next Quality Assurance meeting on March 25th, 2025.

Licensee's Proposed Overall Completion Date: 03/10/2025

Implemented [REDACTED] 04/25/2025)

91 - Telephone Numbers

6. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

91 - Telephone Numbers (continued)

**Description of Violation**

On 2/19/25 at approximately 12:03 p.m. the emergency telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline were not posted on or near the telephone resting on the armrest of resident #3's recliner in resident room # [REDACTED]

On 2/19/25 at approximately 12:38 p.m. the emergency telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline were not posted near the cellular telephone resting on the table next to resident #4's bedside or anywhere else in resident room [REDACTED]

On 2/19/25 at approximately 1:12 p.m. the emergency telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline were not posted on or near the telephone mounted to the wall in the vestibule between the home's lobby and the front parking lot.

On 2/19/25 at approximately 3:35 p.m. the emergency telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline were not posted on or near the telephone resting on the ledge next to the home's posting board to the right of the elevator.

**Plan of Correction**

Accept [REDACTED] 03/11/2025)

*ACTION:* On 2/19/25, immediately after inspection, the home's staff placed emergency numbers on telephones that did not have them in place.

*TRAINING:* On 3/5/2025 the home's concierge staff and management staff which includes the Executive Director, Maintenance Director, Director of Dining Services, Memory Care Coordinator, Resident Care Coordinator, Life Enrichment Director and Sales Director, received training on regulation 2600.95. Documentation of the staff training shall be kept in accordance with 2600.65i.

*ONGOING:* On 3/5/2025 the home's management staff which includes the Executive Director, Maintenance Director, Director of Dining Services, Memory Care Director, Resident Care Coordinator, Life Enrichment Director and Sales Director, started resident room audits. These audits include but are not limited to ensuring emergency telephone numbers are in place. These audits are conducted a minimum of 3 times weekly for the next 30 days to ensure compliance with regulation 2600.91. A record of these audits will be kept in the administrator's office. Extra emergency phone number tags we made and put in place at the front desk in the event a phone tag is damaged or removed it will be replaced timely.

Licensee's Proposed Overall Completion Date: 03/10/2025

Implemented [REDACTED] 04/25/2025)

95 - Furniture and Equipment

**7. Requirements**

2600.

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

**Description of Violation**

On 2/19/25 at approximately 3:08 p.m., the escutcheon plate for the right side of the grab bar behind the toilet in the private bathroom of resident room #115 belonging to resident #5 was loose and unsecured to the wall.

95 - Furniture and Equipment (continued)

**Plan of Correction**

Accept [REDACTED] 03/11/2025)

*ACTION: Immediately after inspection on 2/19/25, the home's maintenance director repaired the loose escutcheon plate in room [REDACTED]*

*TRAINING: On 3/5/2025 the home's management staff which includes the Executive Director, Maintenance Director, Director of Dining Services, Memory Care Coordinator, Resident Care Coordinator, Life Enrichment Director and Sales Director received training on regulation 2600.95. A record of this training will be kept in the administrator's office. Staff postings were also put in place on 2/24/25 to reiterate the expectations in resident rooms. Documentation of the staff training shall be kept in accordance with 2600.65i.*

*ONGOING: On 3/5/2025 the home's management staff which includes the Executive Director, Maintenance Director, Director of Dining Services, Memory Care Director, Resident Care Coordinator, Life Enrichment Coordinator and Sales Director, started resident room audits. These audits are conducted a minimum of 3 times weekly for the next 30 days to ensure compliance with regulation 2600.95. A record of these audits will be kept in the administrator's office. A review of these audits will occur at the home's next monthly Quality Assurance Meeting starting on March 25th, 2025.*

**Licensee's Proposed Overall Completion Date: 03/10/2025**

Implemented [REDACTED] 04/25/2025)

100a - Exterior - Free of Hazards

**8. 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 2/19/25 at 3:35 p.m. the concrete pad to the left of the emergency egress route from the Garden Room lounge was shattered and cracked with multiple sections of concrete missing or displaced and presented a tripping hazard for any resident with a walker or unsteady gait.*

**Plan of Correction**

Accept [REDACTED] 03/11/2025)

*ACTION: Immediately after inspection on 2/19/25, the home's maintenance director removed any loose concrete pieces that posed a tripping hazard, and an emergency cone was put in place until repairs were made. On 3/4/25 the home's maintenance director patched the cracked area with quick concrete, area is now smooth and poses no tripping hazard.*

*TRAINING: On 3/5/2025 the home's maintenance assistant as well as the management staff which includes the Executive Director, Maintenance Director, Director of Dining Services, Memory Care Coordinator, Resident Care Coordinator, Life Enrichment Director and Sales Director, received training on regulation 2600.100.a, a record of this training will be kept in the administrator's office.*

*ONGOING: On 3/5/2025 the home's management staff which includes the Executive Director, Maintenance Director, Director of Dining Services, Memory Care Coordinator, Resident Care Coordinator, Life Enrichment Director and Sales Director, started resident room audits. Audits include but are not limited to confirming compliance with regulation 2600.100.a. These audits are conducted a minimum of 3 times weekly for the next 30 days to ensure compliance with regulation 2600.100.a. A record of these audits will be kept in the administrator's office. A review of these audits*

100a - Exterior - Free of Hazards (continued)

will occur at the home's next monthly Quality Assurance Meeting starting on March 25th, 2025.

Licensee's Proposed Overall Completion Date: 03/10/2025

Implemented (██████) 04/25/2025)

101j5 - Bedside Table/Shelf

9. Requirements

2600.

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

5. A bedside table or a shelf.

Description of Violation

On 2/19/25 at approximately 3:03 p.m. there was no bedside table or shelf at bedside for resident #6 in resident room #149 belonging to resident #6 and resident #7.

Plan of Correction

Accepted (██████) 03/11/2025)

ACTION: Immediately following inspection on 2/19/25, an additional bedside table was put in place for resident #6 by the home's Maintenance Assistant.

TRAINING: On 3/5/2025 the home's maintenance assistant as well as the management staff which includes the Executive Director, Maintenance Director, Director of Dining Services, Memory Care Coordinator, Resident Care Coordinator, Life Enrichment Director and Sales Director, received training on regulation 2600.101.j, Documentation of the staff training shall be kept in accordance with 2600.65i.

Staff postings were also put in place on 2/24/25 to reiterate the expectations in resident rooms.

ONGOING: On 3/5/2025 the home's management staff which includes the Executive Director, Maintenance Director, Director of Dining Services, Memory Care Coordinator, Resident Care Coordinator, Life Enrichment Director and Sales Director, started resident room audits. Audits include but are not limited to confirming compliance with regulation 2600.101.j. These audits are conducted a minimum of 3 times weekly for the next 30 days to ensure compliance with regulation 2600.101.j. A record of these audits will be kept in the administrator's office. A review of these audits will occur at the home's next monthly Quality Assurance Meeting starting on March 25th, 2025.

Licensee's Proposed Overall Completion Date: 03/10/2025

Implemented (██████) 04/25/2025)

101j7 - Lighting/Operable Lamp

10. Requirements

2600.

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

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

Description of Violation

On 2/19/25 at approximately 3:20 p.m. the switch to operate the light source at bedside for resident #1 in resident room #148 was not within reach of the resident's bedside.

On 2/19/25 at approximately 3:03 p.m. there was no operable source of light at bedside for resident #6 in resident room #149 belonging to resident #6 and resident #7.

Plan of Correction

Accepted (██████) 03/14/2025)

ACTION: Immediately following inspection on 2/19/25, an additional bedside lamp was put within reach for

101j7 - Lighting/Operable Lamp (continued)

resident #1, and resident #6, by the home's Maintenance Assistant.

*TRAINING: On 3/5/2025 the home's maintenance assistant as well as the management staff which includes the Executive Director, Maintenance Director, Director of Dining Services, Memory Care Coordinator, Resident Care Coordinator, Life Enrichment Director and Sales Director, received training on regulation 2600.101.j, a record of this training will be kept in the administrator's office. Staff postings were also put in place on 2/24/25 to reiterate the expectations in resident rooms.*

*ONGOING: On 3/5/2025 the home's management staff which includes the Executive Director, Maintenance Director, Director of Dining Services, Memory Care Director, Resident Care Coordinator, Life Enrichment Coordinator and Sales Director, started resident room audits. These audits are conducted a minimum of 3 times weekly for the next 30 days to ensure compliance with regulation 2600.101.j. A record of these audits will be kept in the administrator's office. A review of these audits will occur at the home's next monthly Quality Assurance Meeting starting on March 25th, 2025.*

**Licensee's Proposed Overall Completion Date: 03/14/2025**

**Implemented [REDACTED] 04/25/2025)**

102h - Toilet Paper

11. Requirements

2600.

102.h. Toilet paper shall be provided for every toilet.

**Description of Violation**

*On 2/19/25 at approximately 12:16 p.m. there was no toilet paper in the private bathroom of resident room #243 belonging to resident #2.*

**Plan of Correction**

**Accept [REDACTED] 03/11/2025)**

*ACTION: Immediately following inspection on 2/19/25, toilet paper was restocked for resident #2. Additionally, housekeeping staff also confirmed that all other resident units were stocked with toilet paper.*

*TRAINING: On 3/5/2025 the home's maintenance assistant and housekeeping staff, as well as the management staff which includes the Executive Director, Maintenance Director, Director of Dining Services, Memory Care Coordinator, Resident Care Coordinator, Life Enrichment Director and Sales Director, received training on regulation 2600.102.h., a record of this training will be kept in the administrator's office. Staff postings were also put in place on 2/24/25 to reiterate the expectations in resident rooms.*

*ONGOING: On 3/5/2025 the home's management staff which includes the Executive Director, Maintenance Director, Director of Dining Services, Memory Care Director, Resident Care Coordinator, Life Enrichment Coordinator and Sales Director, started resident room audits. This audit includes but is not limited to confirming compliance with regulation 2600.102.h. These audits are conducted a minimum of 3 times weekly for the next 30 days to ensure compliance with regulation 2600.101.j. A record of these audits will be kept in the administrator's office. A review of these audits will occur at the home's next monthly Quality Assurance Meeting starting on March 25th, 2025.*

**Licensee's Proposed Overall Completion Date: 03/10/2025**

**Implemented [REDACTED] 04/25/2025)**

103g - Storing Food

12. Requirements

2600.

103g - Storing Food *(continued)*

103.g. Food shall be stored in closed or sealed containers.

**Description of Violation**

*On 2/19/25 at approximately 12:32 p.m., above the hand sink in the kitchenette across from resident room #227, there was an opened and unsealed one-pound bag of UTZ brand thin pretzels that was approximately one-half full as well as an open and unsealed seven-point-seven-five-ounce bag of Giant Eagle branded wavy potato chips that was also approximately one-half full. Additionally, there was a twelve-ounce bag of sweetened dried Great Value brand Mango slices that was approximately two-thirds full that was also open and unsealed.*

*On 2/19/25 at approximately 2:18 p.m. there was a five-pound bag of breaded frozen chicken breasts that was approximately two-thirds full and was found opened and unsealed in the home's two-door TRUE branded upright freezer.*

**Plan of Correction**

Accept [REDACTED] 03/11/2025)

*ACTION: Immediately after inspection on 2/19/25, all unsealed and open food items identified were discarded by the Director of Dining services.*

*TRAINING: On 3/5/2025 the home's housekeeping staff, cooks and management staff which includes the Executive Director, Maintenance Director, Director of Dining Services, Memory Care Coordinator, Resident Care Coordinator, Life Enrichment Director and Sales Director, received training on regulation 2600.102.h., a record of this training will be kept in the administrator's office.*

*ONGOING: On 3/5/2025 the home's management staff which includes the Executive Director, Maintenance Director, Director of Dining Services, Memory Care Director, Resident Care Coordinator, Life Enrichment Coordinator and Sales Director, started kitchenette audits. Audits include but are not limited to confirming compliance with regulation 2600.103.g. These audits are conducted a minimum of 3 times weekly for the next 30 days to ensure compliance with regulation 2600.103.g. A record of these audits will be kept in the administrator's office. A review of these audits will occur at the home's next monthly Quality Assurance Meeting starting March 25th, 2025.*

**Licensee's Proposed Overall Completion Date: 03/10/2025**

Implemented [REDACTED] 04/25/2025)

105g - Lint Removal and Duct Cleaning

**13. Requirements**

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

**Description of Violation**

*On 2/19/25 at approximately 12:48 p.m., the Hotpoint brand dryer located in the laundry room across from resident room #228 had a build-up of white lint with blue and purple patches that coated the entire lint screen in a layer approximately one-sixteenth of an inch thick.*

*On 2/19/25 at approximately 2:27 p.m., in the main laundry room off the home's kitchen area the Hotpoint brand dryer lint screen was matted with a thin layer of grey, purple, and white lint.*

*On 2/19/25 at approximately 2:40 p.m. the lint screen of UNIMAC brand industrial dryer in the home's Along the Journey memory care unit was matted with white and grey lint that was approximately one-sixteenth of an inch thick.*

105g - Lint Removal and Duct Cleaning (continued)

Plan of Correction

Accept [redacted] - 03/11/2025)

ACTION: Immediately after inspection on 2/19/25, all dryer lint traps were thoroughly cleaned by the home's Maintenance Assistant.

TRAINING: On 3/5/2025 the home's maintenance assistant and housekeeping staff, as well as the management staff which includes the Executive Director, Maintenance Director, Director of Dining Services, Memory Care Coordinator, Resident Care Coordinator, Life Enrichment Director and Sales Director, received training on regulation 2600.105.g., a record of this training will be kept in the administrator's office.

ONGOING: Signs have been placed on each dryer to remind staff members to clean after each use. Audits are conducted a minimum of 3 times weekly for the next 30 days to ensure compliance with regulation 2600.105.g. A review of these audits will occur at the home's next monthly Quality Assurance Meeting starting March 25th, 2025.

Licensee's Proposed Overall Completion Date: 03/10/2025

Implemented [redacted] 04/25/2025)

132c - Fire Drill Records

14. Requirements

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

On 8/21/24 at 2:04 the home conducted a fire drill, however, the fire drill record did not indicate "a.m." or "p.m." for the time of the drill and indicated "no" for exit route(s) used.

On 8/22/24 at 1:26 the home conducted a fire drill, however, the fire drill record did not indicate "a.m." or "p.m." for the time of the drill and indicated "yes" for exit route(s) used.

Plan of Correction

Accept [redacted] 03/11/2025)

ACTION: Immediately after inspection on 2/19/25, the home's administrator reviewed the fire drill log and confirmed that all drills after those held in August 2024 were all in compliance was 2600.132.c. and that

TRAINING: On 3/5/25 the home's maintenance assistant and Maintenance Director received training on regulation 2600.102.h., a record of this training will be kept in the administrator's office.

ONGOING: At the conclusion of all future fire drills both the Maintenance Director and Administrator will review the fire drill log to ensure all information has been recorded on the log appropriately. As part of the home's monthly Quality Assurance meeting the Administrator will review the fire drill log to ensure all fire drill documentation has been recorded appropriately starting March 25th, 2025.

Licensee's Proposed Overall Completion Date: 03/10/2025

Implemented [redacted] 04/25/2025)

132d - Evacuation

15. Requirements

2600.

132d - Evacuation (continued)

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

On 8/21/24 the home conducted a fire drill with 70 residents in the home, however, the fire drill record indicated that only 62 residents were evacuated to a public thoroughfare or fire safe area designated in writing by a fire safety expert.

Plan of Correction

Accept [redacted] - 03/11/2025

ACTION:

A follow up fire drill was conducted on 8/22/2025 in response to the failed drill by the Maintenance department.

TRAINING: On 3/5/2025 the home's maintenance assistant, as well as the management staff which includes the Executive Director, Maintenance Director, Director of Dining Services, Memory Care Coordinator, Resident Care Coordinator, Life Enrichment Director and Sales Director, received training on regulation 2600.132.d., a record of this training will be kept in the administrator's office.

ONGOING: At the conclusion of all future fire drills both the Maintenance Director and Administrator will review the fire drill log to ensure all information has been recorded on the log appropriately.

All residents who reside in the community will be evacuated during every drill.

As part of the home's monthly Quality Assurance meeting the Administrator will review the fire drill log to ensure all fire drill documentation has been recorded appropriately starting on March 25th, 2025.

Licensee's Proposed Overall Completion Date: 03/10/2025

Implemented [redacted] 04/25/2025

141a 1-10 Medical Evaluation Information

16. 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. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #4's annual medical evaluation, dated [redacted] 25, indicated "see attachment" in the medications section, however, the attached medication list indicated "Report Run: 2/5/25" and the form was signed and dated by the medical professional on [redacted] 25.

Resident #3's medical evaluation, dated [redacted] 24, did not indicate none or see "medication addendum" below in the medications section, the medication addendum section was left blank and medication list attached to the form was dated 3/5/24.

## 141a 1-10 Medical Evaluation Information (continued)

**Plan of Correction****Directed** [REDACTED] 03/14/2025)**ACTION:**

Resident #3 medication addendum was updated on March 1, 2025 by the Administrator. Original attachment from resident's medical evaluation was missing and a new copy was printed for file.

**TRAINING:**

On March 5, 2025 The Director of Nursing and Resident Care Coordinator have been trained by the administrator on regulation 2600.141.a to ensure that the forms are fully completed. Documentation of the staff training shall be kept in accordance with 2600.65i.

**ONGOING:**

DON and RCC will ensure that when a DME is returned from any PCP any referenced attachments are returned with the DME and filed accordingly. An audit started March 1, 2025, of all DME forms, this audit will be completed by April 15, 2025, documentation of this audit shall be kept in the administrative office. This audit will include confirmation of any attachments referenced on the DMEs.

Proposed Overall Completion Date: 04/15/2025

**DIRECTED**

Within 1 day of receipt of the accepted plan of correction: The administrator shall update resident #4's medical evaluation documentation to include an accurate medication regimen. [REDACTED] 3/14/25

**Directed Completion Date:** 04/15/2025

**Implemented** [REDACTED] 04/25/2025)

## 183d - Prescription Current

**17. Requirements**

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

**Description of Violation**

On 2/20/25 at approximately 10:29 a.m. there was a box of Duoderm that was labeled "Apply topically to [REDACTED] toe every 3 days until healed" that belonged to resident #3 and was found on the home's medication cart. However, resident #3's Duoderm was discontinued on 10/1/24.

On 2/20/25 at approximately 10:52 a.m. there was a Ziplock bag containing six 4mg tablets of Ondansetron that was labeled "Take one tablet by mouth four times a day as needed" for resident #4 that was found on the home's medication cart. However, resident #4's Ondansetron 4mg tablet was discontinued on 1/23/25.

**Plan of Correction****Accept** [REDACTED] 03/11/2025)

**ACTION:** The discontinued medications identified were immediately removed from the cart at the time of inspection February 20, 2025, by the Resident Care Coordinator.

**TRAINING:** All med trained staff are being trained on regulation 2600.183d by the Executive Director and will be completed by 3/14/2025. Documentation of the training will be kept in the administrator's office.

**ONGOING:** The Director of Nursing, Resident Care Coordinator and Executive Director will conduct weekly MAR to Cart audits on all non-self-medicating residents for 6 weeks beginning 2/28/2025. The community pharmacy will continue to perform monthly MAR to cart audits and provide the Executive Director and Director of Nursing with results which will be kept in a binder along with the audits performed by the community. MAR to cart audits will be

183d - Prescription Current (continued)

reviewed at all future community monthly Quality Assurance meetings and then kept in a binder in the Executive Director's office starting on March 25, 2025.

Licensee's Proposed Overall Completion Date: 03/10/2025

Implemented [redacted] 04/25/2025)

184a - Resident's Meds Labeled

18. Requirements

2600.

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

Description of Violation

The pharmacy label for resident #3's Triad wound paste dressing indicated, "Apply topically to [redacted] after each [redacted] episode once daily until gone." However, resident #3 is prescribed Triad wound paste, apply topically to [redacted] after each incontinent episode once daily as needed for redness/excoriation.

The pharmacy label for resident #4's Lantus 100unit/ml indicated to inject thirty units subcutaneous, nightly. However, resident #4 is prescribed Lantus 100unit/ml, inject thirty-two units subcutaneous, nightly.

Plan of Correction

Accept [redacted] 03/11/2025)

ACTION: A change of direction sticker was placed on both medications immediately at the time of inspection by the Resident Care Coordinator.

TRAINING: All med trained staff are being trained on regulation 2600.184a by the Executive Director and will be completed by 3/14/2025. Documentation of this training will be kept in the Executive Director's office.

ONGOING: The Director of Nursing, Resident Care Coordinator and Executive Director will conduct weekly MAR to Cart audits on all non-self-medicating residents for 6 weeks beginning 2/28/2025. The community pharmacy will continue to perform monthly MAR cart audits and provide the Executive Director and Director of Nursing with results which will be kept in a binder along with the audits performed by the community. Findings from the MAR to cart audits will be reviewed at the community's monthly Quality Assurance meeting and then kept in a binder in the Executive Director's office. A review of these audits will occur at the home's next monthly Quality Assurance Meeting starting on March 25, 2025.

Licensee's Proposed Overall Completion Date: 03/14/2025

Implemented [redacted] - 04/25/2025)

185a - Implement Storage Procedures

19. Requirements

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #3 is prescribed the following medications that were not available in the home on 2/20/25 at approximately 10:10 a.m. to administer if requested by the resident:

- Banophen 25mg tablet, take one tablet by mouth twice daily as needed.
- Fexofenadine 180mg tablet, take one tablet by mouth once daily as needed.

185a - Implement Storage Procedures (continued)

Resident #4 is prescribed Valsartan 40mg tablets, take two tablets (80mg) by mouth once daily. The home did not have a supply of 40mg tablets of Valsartan for resident #4 and instead was administering Valsartan 160mg tablets that were dispensed on 1/31/25 by splitting them in half. However, the 160mg tablets of Valsartan were not scored to be split and the home's medication technicians were discarding the other half of the tablet in the home's drug buster.

On 2/15/25 at approximately 10:13 p.m., resident # 1's blood glucose reading on the resident's glucometer measured 275mg/dL. However, a value of 176mg/dL was entered on the resident's medication administration record(MAR) on 2/15/25 at 11:30 a.m.

On 2/16/25 at approximately 2:17 p.m., resident #4's blood glucose reading on the resident's glucometer measured 281mg/dL. However, a value of 146mg/dL was entered on the resident's medication administration record(MAR) on 2/16/25 at 11:30 a.m.

The home's policy for the accountability of narcotics and controlled substances monitoring indicated "A narcotic count is to be completed and signed by two qualified staff prior to accepting responsibility of the medication cart keys. Any discrepancies with the narcotic count will be reported to the Director of Nursing and Executive Director at the time the discrepancy is found." However, on 2/20/25 it was discovered that the narcotic count for resident #8's Lorazepam (Ativan) 0.5mg tablet was off by a count of one tablet, there were five tablets on the cart when only four should remain and the home could not account for the excess supply of medication.

REPEAT VIOLATION 4/25/24 et. al.

Plan of Correction

Accept [redacted] 03/11/2025)

ACTION:

Resident #3, two medications, Banophen and fexofenadine were immediately ordered, resident #4 Valsartan was immediately ordered in the correct dosage form. The narcotic count was reconciled on February 20, 2025, by the Resident Care Coordinator.

TRAINING:

All med trained staff are being trained on regulation 2600.185a by the Executive Director and will be completed by 3/14/2025. Documentation of this training will be kept in the Executive Director's office.

ONGOING:

Beginning March 1, 2025, a complete MAR to cart audit will be done for 5 residents in PC and 5 residents in MC weekly for the next six weeks along with daily glucometer checks, documentation of these audits will be kept in the administrator's office. A narcotic count audit will be conducted weekly by the Director of Nursing, Resident Care Coordinator or designee and documentation will be kept. Findings from the MAR to cart audits will be reviewed at the community's monthly Quality Assurance meeting and then kept in a binder in the Executive Director's office starting on March 25, 2025

Licensee's Proposed Overall Completion Date: 03/14/2025

Implemented [redacted] 04/25/2025)

187a - Medication Record

20. Requirements

2600.

187a - Medication Record (continued)

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

Description of Violation

Resident #4 is prescribed Humalog 100unit/ml sliding scale four times a day 70-140 = 0u, 141-180=2u, 181-220=4u, 221-260=6u, 261-300=8u, 301-340=10u, 341-400=12u (48u daily max). However, the resident's February 2025 medication administration record entry that includes documentation of the administration of this medication indicated "Aspa inj Flexpen for Novolog – inject subcutaneously as directed per sliding scale twice daily at lunch and dinner only, if blood sugar is 70-140=0u, 141-180=2u, 181-220=4u, 221-260=6u, 261-300=8u, 301-340=10u, 341-400=12u."

Resident #8 is prescribed Trazodone HCl 50mg tab(s) oral – one tablet every night at bedtime to begin [redacted]/25. However, resident #8's February 2025 medication administration record did not include an area to document the administration of the Trazodone 50mg tablet.

Plan of Correction

Accept [redacted] 03/14/2025)

ACTION:

Humalog insulin for resident #4 was ordered at the time of the inspection by the Resident Care Coordinator; the pharmacy was also notified to profile Trazadone order for resident #8. Trazadone was properly profiled by the pharmacy and documentation for administration was available on the MAR on 2/20/2025.

TRAINING:

All med trained staff are being trained on regulation 2600.187a by the Executive Director and will be completed by 3/14/2025, which includes ensuring ordered medications are stocked, profiled and documentation of administration is completed per physician's orders. Documentation of the staff training shall be kept in accordance with 2600.65i.

ONGOING:

Beginning March 1, 2025, a complete MAR to CART audit will be done for 5 residents in PC and 5 residents in MC weekly for six weeks, documentation of this audit will be kept in the administrator's office. A narcotic count audit will be conducted weekly by DON, RCC or designee and documentation will be kept. A review of these audits will occur at the home's next monthly Quality Assurance Meeting starting on March 25, 2025.

Proposed Overall Completion Date: 03/14/2025

Licensee's Proposed Overall Completion Date: 03/14/2025

Implemented [redacted] 04/25/2025)

187b - Date/Time of Medication Admin.

21. Requirements

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #1 is prescribed a daily regimen of multiple medications that were placed on hold on [redacted] 25 due to a hospital trip. Resident #1 returned from the hospital late in the evening on [redacted] 25 and the hold was not removed from the medication administration record until the morning of [redacted] 25. The resident's medications were all passed but were not documented at the time of administration in the February 2025 medication administration record to include:

- Aspirin Chewable 81mg, take one tablet by mouth once daily.

187b - Date/Time of Medication Admin. (continued)

- *Atenolol Tablet 25mg, Take ½ tablet = 12.5mg by mouth once daily.*
- *Basaglar INJ 100UNIT, Inject 14 units subcutaneously at bedtime.*
- *Humalog INJ 100Unit, Inject subcutaneously as directed per sliding scale before meals and at bedtime; if blood sugar is 201-250=2 units, 251-300=5 units, 301-350=8 units, 351-400=10 units, 401-450=12 units*
- *Melatonin Tablet 3mg, take 1 tablet by mouth at bedtime.*
- *Multivitamin Tablet, take 1 tablet by mouth once daily.*
- *Omega-3 Fish Capsule 1000mg, take 1 capsule by mouth once daily.*
- *Oseltamivir Capsule 75mg, take 1 capsule by mouth twice daily.*
- *Paroxetine Tablet 40mg, take 1 tablet by mouth once daily.*
- *Simvastatin Tablet 80mg, take 1 tablet by mouth once daily.*

*Resident #8 is prescribed Trazodone HCl 50mg tab(s) oral – one tablet every night at bedtime to begin 2/11/25. However, there was no record of resident #8 being administered the Trazodone 50mg tablet in February 2025.*

*Resident #8 is prescribed Lorazepam (Ativan) 0.5mg tab(s) oral – one tablet twice daily to begin 1/24/25. On 2/20/25 the electronic narcotics inventory log indicated an error in the count when confirming a remaining supply of five tablets. On dates ranging from 2/13/25 through 2/20/25 all entries for the Lorazepam were documented as administered to resident #8, however, on dates ranging from 2/13/25 through 2/20/25, the resident was not administered one dose of the Lorazepam 0.5mg tablet.*

**Plan of Correction**

**Accept** [REDACTED] 03/14/2025)

**ACTION:**

*Medications were taken off hold on 2/14/2025 for Resident #1. For Resident #8, the trazadone was properly profiled by the pharmacy and documentations for administration was available on the MAR on 2/20/2025. The narcotic count was reconciled by the Resident Care Coordinator on 2/20/2025.*

**TRAINING:**

*All med trained staff were trained on regulation 2600.187.b by the Executive Director, this will be completed by March 14, 2025. Training included ensuring ordered medications are stocked, profiled, documentation of administration is completed per physician's orders. Documentation of the staff training shall be kept in accordance with 2600.65i.*

**ONGOING:**

*Beginning March 1, 2025, a complete MAR to CART will be done for 5 residents in PC and 5 residents in MC weekly for six weeks. A narcotic count audit will be conducted weekly by DON, RCC or designee and documentation will be kept in the administrator's office. A review of these audits will occur at the home's next monthly Quality Assurance Meeting starting on March 25, 2025.*

**Licensee's Proposed Overall Completion Date: 03/14/2025**

**Implemented** [REDACTED] - 04/25/2025)

187d - Follow Prescriber's Orders

**22. Requirements**

- 2600.
- 187.d. The home shall follow the directions of the prescriber.

187d - Follow Prescriber's Orders (continued)

**Description of Violation**

Resident #4 is prescribed Valsartan 40mg tablets, take two tablets (80mg) by mouth once daily. However, on 2/20/25, the home had a blister pack of Valsartan 160mg tablets, the pills were not scored to be split, and staff interviews indicated the home's medication technicians were splitting the Valsartan tablets to give to resident #4 and could not ensure the prescribed dose of 80mg was administered to the resident.

Resident #8 is prescribed Trazodone HCl 50mg tab(s) oral – one tablet every night at bedtime to begin 2/11/25. However, resident #8's blister pack of medication received on 2/12/25 was only missing two tablets of the medication and resident #8 was not administered the prescribed dose of medication on five unknown dates ranging from 2/12/25 through 2/19/25.

Resident #8 is prescribed Lorazepam (Ativan) 0.5mg tab(s) oral – one tablet twice daily to begin 1/24/25. On 2/20/25 the electronic narcotics inventory log indicated an error in the count when confirming a remaining supply of five tablets. On dates ranging from 2/13/25 through 2/20/25 resident #8 [REDACTED] was not administered one dose of the Lorazepam 0.5mg tablet.

REPEAT VIOLATION 7/22/24 et. al.

**Plan of Correction**

Accept [REDACTED] 03/14/2025)

**ACTION:**

On 2/20/2025 the prescribed Valsartan was ordered and received from the pharmacy; the pharmacy was notified of the need to profile resident #8 Trazadone. The narcotic count was reconciled by the Resident Care Coordinator.

**TRAINING:**

All med trained staff are being trained on regulation 2600.187d by the Executive Director and will be completed by 3/14/2025, which includes ensuring ordered medications are stocked and administered per MD orders, unscored medications are not to be cut, and narcotic counts must be checked and reconciled at the end of each shift.

Documentation of the staff training shall be kept in accordance with 2600.65i.

**ON-GOING:**

Beginning March 1, 2025 a complete MAR to CART will be done for 5 residents in PC and 5 residents in MC weekly for six weeks. A narcotic count audit will be conducted weekly by DON, RCC or designee. Documentation of these audits will be kept in the administrator's office. A review of these audits will occur at the home's next monthly Quality Assurance Meeting starting on March 25, 2025.

Licensee's Proposed Overall Completion Date: 03/14/2025

Implemented ([REDACTED] - 04/25/2025)

225a - Assessment 15 Days

**23. 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**

On [REDACTED] 24 at approximately 12:03 p.m., a two-handled stepstool serving as a bedside mobility device was found affixed to the right-side of resident #3's bed in resident room [REDACTED]. However, resident #3's assessment, dated [REDACTED] 24, indicated the resident is independent with transfers in/out of bed/chair, and the assessment summary did not include

225a - Assessment 15 Days (continued)

the use of the bedside mobility device.

REPEAT VIOLATION 10/22/24 et. al.

Plan of Correction

Accept [REDACTED] 03/11/2025)

ACTION:

Resident #3's assessment updated on [REDACTED] 2025 by the Administrator to reflect [REDACTED] current needs.

TRAINING:

On 3/5/2025 The Director of Nursing and Resident Care Coordinator was provided with training on 2600.225.a. Documentation of the staff training shall be kept in accordance with 2600.65i.

ONGOING:

Starting March 1, 2025 three assessments per week are being audited to ensure that all information is current and reflects the residents' needs. The audits are being completed by the Director of Nursing, Resident Care Coordinator, Memory Care Coordinator and the Administrator. Documentation of the audits shall be kept in the Administrative Office. A review of these audits will occur at the home's next monthly Quality Assurance Meeting starting on March 25, 2025.

Licensee's Proposed Overall Completion Date: 03/10/2025

Implemented [REDACTED] 04/25/2025)

227g -Support Plan Signatures

24. 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 #8's annual support plan, dated [REDACTED]/24, was not signed by the assessor, direct care staff person C.

Plan of Correction

Accept [REDACTED] - 03/14/2025)

ACTION:

The support plan was reviewed by the Administrator and signed, as the original assessor is not available on [REDACTED]

TRAINING:

On 3/5/2025 the Director of Nursing and Resident Care Coordinator was provided with an in-service on the need for the assessor to sign the support plan once completed. Documentation of this staff training shall be kept in accordance with 2600.65i.

ONGOING:

Starting March 1, 2025, an audit of signature compliance began for all support plans. This audit will be completed by March 31, 2025, and documentation of this audit shall be kept in the administrative office. A review of these audits will occur at the home's next monthly Quality Assurance Meeting starting on March 25, 2025.

Licensee's Proposed Overall Completion Date: 03/31/2025

Implemented [REDACTED] - 04/25/2025)

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

April 25, 2025

[REDACTED]  
EC OPCO LAKEMONT FARMS LLC  
[REDACTED]

RE: CELEBRATION VILLA OF LAKEMONT  
FARMS  
3275 WASHINGTON PIKE  
BRIDGEVILLE, PA, 15017  
LICENSE/COC#: 45081

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 04/21/2025 of the above facility, no regulatory citations have been identified as a result of this inspection.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,  
[REDACTED]

Enclosure  
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

Name: *CELEBRATION VILLA OF LAKEMONT FARMS* License #: *45081* License Expiration: *05/05/2025*  
 Address: *3275 WASHINGTON PIKE, BRIDGEVILLE, PA 15017*  
 County: *ALLEGHENY* Region: *WESTERN*

**Administrator**

Name [REDACTED]

**Legal Entity**

Name: *EC OPCO LAKEMONT FARMS LLC*  
 Address [REDACTED]  
 Phone: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: *03/17/1999* Issued By: *Depart of L&I*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *95* Waking Staff: *71*

**Inspection Information**

Type: *Partial* Notice: *Unannounced* BHA Docket #:  
 Reason: *Monitoring* Exit Conference Date: *04/21/2025*

**Inspection Dates and Department Representative**

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

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *140* Residents Served: *63*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *Along the Journey* Capacity: *30* Residents Served: *16*

**Hospice**

Current Residents: *10*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *63*  
 Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*  
 Have Mobility Need: *32* Have Physical Disability: *0*

**Inspections / Reviews**

04/21/2025 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *Not Required*

**NO DEFICIENCIES FOUND**