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

June 10, 2025

[REDACTED], EXECUTIVE DIRECTOR
MCCANDLESS SQUARE SENIOR LIVING LLC

RE: ASHTON COMMONS SENIOR LIVING
551 COOPER STREET
WEXFORD, PA, 15090
LICENSE/COC#: 45354

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/03/2025 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ASHTON COMMONS SENIOR LIVING* **License #**: *45354* **License Expiration**: *08/14/2025*

Address: *551 COOPER STREET, WEXFORD, PA 15090*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *MCCANDLESS SQUARE SENIOR LIVING LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *01/19/2022* **Issued By**: *Township of McCandless*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *128* **Waking Staff**: *96*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *04/17/2025*

Inspection Dates and Department Representative

04/03/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *109* **Residents Served**: *98*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *1st Floor* **Capacity**: *16* **Residents Served**: *16*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *98*

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

Have Mobility Need: *30* **Have Physical Disability**: *0*

Inspections / Reviews

04/03/2025 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/03/2025*

05/21/2025 - POC Submission

Submitted By: **Date Submitted**: *06/09/2025*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/28/2025*

Inspections / Reviews *(continued)*

06/02/2025 - POC Submission

Submitted By: [redacted]

Date Submitted: *06/09/2025*

Reviewer: [redacted]

Follow-Up Type: *Document Submission* **Follow-Up Date**: *06/07/2025*

06/10/2025 - Document Submission

Submitted By: [redacted]

Date Submitted: *06/09/2025*

Reviewer: [redacted]

Follow-Up Type: *Not Required*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 4/3/25 at 11:55 a.m., the licensing inspection summary dated 12/19/24 was not posted in the home.

Plan of Correction ***Accept (- 05/21/2025)***

-On 4/3/2025, ED immediately verified that most recent licensing inspection was present and posted in the home.
-On 4/8/2025, Ed was educated on the requirements of 2600.3.c by the Director of Clinical Operations. Documentation of Education will be kept on file in ED office.
-ED will conduct audit of Licensing Binder once a week for one month and monthly for 6 months to ensure that the most current licensing inspection is present and posted in a conspicuous and public place.
-Review of audit will be conducted at the Quality Management Meeting on 5/30/2025.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented (- 06/10/2025)

25c2 - Fee Schedule

2. Requirements

2600.
25.c. At a minimum, the contract must specify the following:
2. A fee schedule that lists the specify the following: actual amount of allowable resident charges for each of the home's available services.

Description of Violation

The contract, dated for resident #1 does not include the actual amount the resident will be charged per month for the home's available services.

Plan of Correction ***Accept (- 05/21/2025)***

-Resident #1 has moved out of the community.
-On 4/25/2025, ED, MCD and BOM were educated on the requirements of 2600.25.c.2. Documentation of education will be kept on file in the ED office.
-Beginning on 4/25/2025 and continuing until completion an whole house audit of resident home contracts will be conducted to ensure actual amount of allowable charges per month are listed.
-Beginning on 4/25/2025 and ongoing, ED implemented a move in checklist to be used for every new move-in, that includes verification that all components of the resident home contract are complete and compliant.
-Review of audit will be conducted at the Quality Management Meeting on 5/30/2025.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented (- 06/10/2025)

42b - Abuse

3. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

42b - Abuse *(continued)*

Description of Violation

Resident #2 has a diagnosis of dementia and resides on the secured dementia care unit (SDCU). On 2/26/25, the home assessed the resident as needing "24 hour a day supervision for [redacted] own safety."

On 4/4/25 between approximately 8:40 p.m. and 9:00 p.m., resident #2 fell out of bed onto the floor. Staff did not discover resident #2, who was still lying on the floor, until approximately 6:11 a.m. on 4/5/25.

Resident #2 sustained [redacted].

Repeat Violation: 9/25/24

Plan of Correction ***Accept ([redacted] - 06/02/2025)***

-on [redacted] Staff members responsible for supervising resident #2 were suspended pending investigation.
-on 4/5/2025, Adult Protective Services were called by ED and initial report of suspected neglect was filed.
-on 4/5/2025, DHS Reportable Incident form was electronically sent per regulation.
-on 4/5/2025, whole house education was conducted by the Executive Director and Wellness Director on identifying, preventing and reporting allegations of abuse and neglect. Documentation of education will be kept on file in the ED office.
-on [redacted], both staff members responsible for supervising resident #2 were terminated.
-beginning 4/28/2025, all staff members were re-educated on identifying, preventing and reporting allegations of abuse and neglect using the OAPSA approved power-point education. Documentation will be kept on file in ED office.
-Beginning on 4/25/2025 and ongoing, MC Director will audit the rounding sheets with caregiver signoff daily to ensure staff accountability. Documentation will be kept on file in the MC Director office.
-Review of audit will be conducted at the Quality Management Meeting on 5/30/2025.
-Beginning 5/21/2025, Shift Clinical Supervisor will provide daily unannounced spot checks to ensure staff is actively providing safety checks. This will be done on every shift and documentation of checks will be reviewed by Executive Director weekly. Results will be reviewed at Quality Management Meeting on 5/30/2025 and again on June 27, 2025.

Licensee's Proposed Overall Completion Date: *06/27/2025*

Implemented ([redacted] - 06/10/2025)

65a - FS Orientation 1st Day

4. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.

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

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

Description of Violation

Staff person A, hired [redacted] did not receive orientation in any of the required topics in accordance with 2600.65a.

Plan of Correction ***Accept ([redacted] - 05/21/2025)***

-On 4/25/2025, ED and BOM were educated on the requirements of 2600.65.a. by Regional Director of Clinical Operations. Documentation will be kept on file in ED Office.
-By 5/4/2025, Staff Person A will be retrained on Evacuation procedures; Staff duties and responsibilities during fire drills, as well as emergency evacuation, transportation and at an emergency location, if applicable; The designated meeting place outside the building or within the fire-safe area in the event of an actual fire; smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable; The location and use of fire extinguishers; smoke detectors and fire alarms and Telephone use ad notification of emergency services.
-Beginning on 4/28/2025 and continuing until completion, Business Office Manager will audit all staff records to ensure all training is completed. Documentation of audit will be kept on file in the business office.
-Beginning on 4/28/2025 and ongoing, Business office Manager revised the new hire orientation checklist to ensure that all requirements of 2600.65.a are included in new hire training and verified on the day of orientation. Checklist will be kept in Business office and reviewed by ED prior to end of every orientation to verify compliance.
-Review of audit will be conducted at the Quality Management Meeting on 5/30/2025.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented ([redacted] - 06/10/2025)

65b - Rights/Abuse 40 Hours

5. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. §§ 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A, hired [redacted], completed their 40th scheduled work hour; however, has not received orientation in any of the required topics in accordance with 2600.65b.

Plan of Correction ***Accept ([redacted] - 05/21/2025)***

-On 4/25/2025, ED and BOM were educated on the requirements of 2600.65.a. by Regional Director of Clinical Operations. Documentation will be kept on file in ED Office.
-By 5/4/2025, Staff Person A will be retrained on Resident Rights, Emergency Medical plan, Mandatory reporting of abuse and neglect under the Older adult Protective Services act and Reporting of reportable incidents and conditions.

65b - Rights/Abuse 40 Hours (continued)

-Beginning on 4/28/2025 and continuing until completion, Business Office Manager will audit all staff records to ensure all training is completed. Documentation of audit will be kept on file in the business office.
-Beginning on 4/28/2025 and ongoing, Business office Manager revised the new hire orientation checklist to ensure that all requirements of 2600.65.a are included in new hire training and verified on the day of orientation.
-Review of audit will be conducted at the Quality Management Meeting on 5/30/2025.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented (█ - 06/10/2025)

81b - Resident Personal Equipment

6. Requirements

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

Description of Violation

On 4/4/25, the enabler bar on resident #3’s bed was not well-secured, and the device could be moved approximately 2’ away from the bed, posing an entrapment and fall hazard.

Plan of Correction ***Accept (█ - 06/02/2025)***

-On 4/4/2025, Resident #3's enabler bar was immediately secured per regulation.
-On 4/25/2025, ED, Maintenance Director, Maintenance Assistant and RN were educated on the requirements of 2600.81.b by the Regional Director of Clinical Operations. Documentation of education will be kept in ED office.
-Beginning on 4/25/2025, All resident enabler bars will be audited once a week for one month and will continue weekly routinely. Documentation of audit will be kept on file in the Maintenance Office.
-Review of audit will be conducted at the Quality Management Meeting on 5/30/2025.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented (█ - 06/10/2025)

85a - Sanitary Conditions

7. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 4/7/25 at 10:12 a.m., there were numerous soiled briefs on the shower floor and hanging from the shower chair in resident #4’s bathroom. There was also a strong odor of urine in the bathroom and the resident’s room.

Plan of Correction ***Accept (█ - 05/21/2025)***

-On 4/7/2025, Staff immediately removed the soiled briefs from resident #4's bathroom.
-On 4/7/2025, Resident #4's room and bathroom were cleaned and sanitized to eliminate risk of infection.
-Beginning on 4/25/2025, Maintenance Director, Maintenance Assistant and all Housekeeping staff was educated on 2600.85.a. by Executive Director. Documentation of education will be kept on file in the ED office.
-Beginning on 5/5/2025, Maintenance will audit 6 resident rooms (2 per floor) randomly to ensure sanitary conditions are being maintained. Audit will continue 1x per week for 1 month and 1x per month for 6 months.

85a - Sanitary Conditions (continued)

Documentation of audit will be kept on file in the Maintenance office.
-Review of audit will be conducted at the Quality Management Meeting on 5/30/2025.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented (- 06/10/2025)

107c - Food/Water 3 Day Supply

8. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 4/7/25, the home served 94 residents, requiring 282 gallons of emergency water. The home has 115 gallons of emergency drinking water were stored on site. There is a contract for water delivery dated 1/20/25, however, the contract does not include the following:
• The amount of water to be delivered
• A guarantee that the water will be delivered immediately upon request, 24-hours-per-day
• A guarantee that the water will be delivered as a priority even in the event of a regional general emergency.

Plan of Correction ***Accept (- 05/21/2025)***

-On 4/25/2025, ED and Maintenance Director were educated by Regional Director of Operations on the requirements of 2600.107.c. Documentation of Education will be kept on file in the ED office.
-By 5/15/2025, ED will secure an updated contract from the company providing emergency water including -The amount of water to be delivered, A guarantee that the water will be delivered immediately upon request, 24 hours per day; A guarantee that the water will be delivered as a priority even in the event of a regional general emergency.

Licensee's Proposed Overall Completion Date: *05/15/2025*

Implemented (- 06/10/2025)

141a - Medical Evaluation

9. 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 #5 was admitted to the home on ; however, the resident's medical examination was completed on more than 60 days prior to admission.

Plan of Correction ***Accept (- 05/21/2025)***

-On 4/25/2025, ED, Move-In Coordinator and Supervising Nurse were educated on the requirements of 2600.141.a by regional director of clinical operations.
-Beginning 4/25/2025 audit of all current Medical Evaluations was conducted to ensure compliance and accuracy. Audit will be completed by 5/30/2025.

141a - Medical Evaluation (continued)

-Beginning 4/25/2025 and ongoing, Move-in Checklist was instituted to ensure all regulatory compliance documentation is complete and accurate prior to new resident move-in. Checklist will be verified and signed by ED prior to every move-in. Checklist will be kept on file in Business Office.
-Review of audit will be conducted at the Quality Management Meeting on 5/30/2025.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented (█ - 06/10/2025)

185a - Implement Storage Procedures

10. 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

On 4/7/25 at 12:17 p.m., resident #4's glucometer was not calibrated to the correct date and time.

Plan of Correction ***Accept (█ - 05/21/2025)***

-On 4/7/2025, Nurse immediately calibrated resident #4's glucometer to the correct time and date.
-Beginning 4/25/2025 all Nurses and Med Tech's were educated on the requirements of 2600.185.a. by Regional Director of clinical operations. Documentation of education will be kept on file in the ED office.
-Beginning on 4/25/2025, supervising nurse will conduct audit of all glucometers to confirm proper calibration. Audit will be conducted 1x per week for one month and then 1x per month for 6 months. Documentation of audit will be kept on file in the ED office.
-Review of audit will be conducted at the Quality Management Meeting on 5/30/2025.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented (█ - 06/10/2025)

190b - Insulin Injections

11. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Staff person C has not successfully completed the Department-approved diabetes patient education program within the last 12 months. However, staff person C administered insulin to resident #4 on 4/5/25 at 7:34 a.m. and 12:08 p.m.

Plan of Correction ***Accept (█ - 05/21/2025)***

-On 4/5/2025, Staff member C was restricted to only administer oral medications until diabetic education can be completed per requirements of 2600.190.b.
-On 4/25/2025, Staff Member C , Scheduler and Supervising Nurse were educated on the requirements of 2600.190.b. by Executive Director. Documentation of education will be kept on file in the ED office.
-Beginning on 4/25/2025, Whole House audit of Med Tech staff was conducted to verify all staff training was up to date. Audit will continue 1x per month to ensure all training is up to date and to prompt appropriate training sessions can be scheduled in a timely manner to ensure no gaps in training. Documentation of Audit will be kept

190b - Insulin Injections (continued)

in ED office.

--Review of audit will be conducted at the Quality Management Meeting on 5/30/2025.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented (- 06/10/2025)

225c - Additional Assessment

12. Requirements

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

Description of Violation

The assessment, dated , for resident #8, does not include an assessment of the resident's personal care need and degree for turning and positioning in bed/chair. This area was blank.

Repeat Violation: 2/27/24

Plan of Correction ***Accept (- 05/21/2025)***

-On 4/25/2025, ED, Move-In Coordinator and Supervising Nurse were educated on the requirements of 2600.141.a by regional director of clinical operations.
-Beginning 4/25/2025 audit of all current Assessments was conducted to ensure compliance and accuracy. Audit will be completed by 5/30/2025.
-Beginning 4/25/2025 and ongoing, Move-in Checklist was instituted to ensure all regulatory compliance documentation is complete and accurate prior to new resident move-in. Checklist will be verified and signed by ED prior to every move-in. Checklist will be kept on file in Business Office.
-Review of audit will be conducted at the Quality Management Meeting on 5/30/2025.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented (- 06/10/2025)

231b - Medical Evaluation

13. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #9 was admitted to the secured dementia care unit (SDCU) on ; however, the medical evaluation, dated does not indicate the need for the resident to be served in a SDCU.

Plan of Correction ***Accept (- 06/02/2025)***

-On 4/3/2025, Memory Care Director immediately obtained new DME that indicated need for SDCU from physician.
-On 4/03/2025, ED, Memory Care Director, Move-In Coordinator and Supervising Nurse were educated on the

231b - Medical Evaluation (continued)

requirements of 2600.141.a by regional director of clinical operations.
-Beginning 4/25/2025 audit of all current Medical Evaluations was conducted to ensure compliance and accuracy. Audit will be completed by 5/30/2025.
-Beginning 4/25/2025 and ongoing, Move-in Checklist was instituted to ensure all regulatory compliance documentation is complete and accurate prior to new resident move-in. Checklist will be verified and signed by ED prior to every move-in. Checklist will be kept on file in Business Office.
-Review of audit will be conducted at the Quality Management Meeting on 5/30/2025.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented (█ - 06/10/2025)

231c - Preadmission Screening

14. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department’s preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #9 was admitted to the SDCU on █, however a written cognitive preadmission screening was not completed.

Plan of Correction ***Accept (█ - 05/21/2025)***

-On 4/7/2025, Memory Care immediately completed a pre admission screening.
-On 4/7/2025, Memory Care Director was educated by Executive Director on the requirements of 2600.231.c
-beginning 4/7/2025, MC Director and Executive Director completed an audit of all pre-admission screenings to ensure completion and accuracy. Audit was completed by 4/25/2025.
-Beginning 4/25/2025 and ongoing, Move-in Checklist was instituted to ensure all regulatory compliance documentation is complete and accurate prior to new resident move-in.Checklist will be verified and signed by ED prior to every move-in. Checklist will be kept on file in Business Office.
-Review of audit will be conducted at the Quality Management Meeting on 5/30/2025.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented (█ - 06/10/2025)