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

August 7, 2025

[redacted], MANAGING MEMBER & OWNER
SAXONY2 LLC
[redacted]

RE: SEASONS OF SAXONBURG
223 PITTSBURGH STREET
SAXONBURG, PA, 16056
LICENSE/COC#: 44943

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/23/2025 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: *SEASONS OF SAXONBURG* **License #:** *44943* **License Expiration:** *07/16/2025*

Address: *223 PITTSBURGH STREET, SAXONBURG, PA 16056*

County: *BUTLER* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *SAXONY2 LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *10/17/2000* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *57* **Waking Staff:** *43*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date:** *06/23/2025*

Inspection Dates and Department Representative

06/23/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *56* **Residents Served:** *39*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *SDCU* **Capacity:** *18* **Residents Served:** *15*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *38*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *18*

Have Physical Disability: *0*

Inspections / Reviews

06/23/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/25/2025*

08/06/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/06/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/13/2025*

Inspections / Reviews *(continued)*

08/06/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/06/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/13/2025*

08/07/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/06/2025*

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

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

At 9:05 a.m., the narcotic count book was unlocked, unattended, and accessible on the medication cart in the B hallway. Count sheets were included in the book for residents #1 & #2.

At 10:30 a.m., the upper half of the door of the nurse's station was open and hospice notes for resident #3 were unlocked, unattended, and accessible.

Plan of Correction ***Accept ([redacted] - 08/06/2025)***

1. The double door was immediately locked by the Administratoe on 5/23/2025 and narcotic book was immediatly locked into the medication cart by the Administrator as immediate corrective measure.
2. Maintenance director secured top half of door to bottom half to prevent future compliance errors on 5/23/2025.
3. The administrator completed a whole house audit on 6/24/2025 checking for any unsecured resident records to measure compliance.
3 All staff educated on 6/26/2025 on regulation 2600.17 by the Administrator. Documentation will be kept on file.
4. Administrator and/or designee will audit all resident records to ensure they are secure, starting 7/1/2025 every week for two months to measure ongoing compliance. Documentation will be kept and reviewed at the monthly QA meeting beginning August 2025.

Licensee's Proposed Overall Completion Date: *08/06/2025*

Implemented ([redacted] - 08/07/2025)

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

At 10:18 a.m., the temperature in the reach in cooler was 44 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 08/06/2025)***

1. Staff was in and out of cooler during the time frame of violation. Refrigerator temperature was rechecked in reach in cooler at 1pm on 6/23/2025 and was reading 41 degree F. the Maintenance Director was immediatly notified of reach in cooler not maintaining correct temperature. At that time an out of order sign was posted on the cooler as immediate corrective measure.
2 Walk in refrigeratoe started being utilized on 6/23/2025 until a repair can be made on reach in cooler to ensure compliance.
3. The Administrator on 6/23/2025 completed a whole house audit of all refrigerators to measure compliance.
4. All staff educated on 6/26/2025 on regulation 2600.103.f. by the Adminstrator. Documentation will be kept on file.
5.Administrator and/or designee will audit refrigerators starting on 7/1/2025 weekly for 5 weeks to ensure ongoing compliance. Documentation will be kept on file and reviewed at the monthly QA meeting beginning in August 2025.

103f - Refrigerator/Freezer Temps *(continued)*

Licensee's Proposed Overall Completion Date: *07/29/2025*

Implemented ([redacted] - 08/07/2025)

121a - Unobstructed Egress

3. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

At approximately 10:45 a.m., the emergency exit door in the B-wing activity room did not open when the panic bar was pushed.

Plan of Correction ***Accept ([redacted] - 08/06/2025)***

1. Maintenance Director installed door release button on door on 6/23/2025 as immediate corrective measure.
2. Maintanence Director completed whole house audit of all doors for proper function and signage on 6/24/2025 to measure compliance.
3.All staff educated on 6/26/2025 on regulation 2600.121.a by the Administrator. Documentation will be kept on file.
5. Maintanence Director and/or designee will audit all doors and signage starting 7/1/2025 twice a month for 2 months. to measure ongoing compliance. Documentation will be kept on file and reviewed at the monthly QA meeting beginning in August 2025

Licensee's Proposed Overall Completion Date: *08/06/2025*

Implemented ([redacted] - 08/07/2025)

132c - Fire Drill Records

4. 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

The fire drill record for the drill conducted for June 2025 does not indicate the date of the drill.

Plan of Correction ***Accept ([redacted] - 08/06/2025)***

1. Maintenance Director added the date to June's firedrill, Inservice sheet was attached to the drill with the date on it. on 6/23/2025 as immediate corrective measure.
2. The Administrator completed an audit of all fire drills for the past 12 months on 6/25/2025 to measure overall compliance.
3. Maintenance Director and all staff educated on 6/25/2025 on regulation 2600.132.c. Documentation will be kept on file.
4. Administrator and/or designee will audit all fire drills for ongoing compliance starting 7/7/2025 for 3 months to measure ongoing compliance. Documentation will be kept and reviewed at the monthly QA meeting begining August 2025.

Licensee's Proposed Overall Completion Date: *08/06/2025*

132c - Fire Drill Records *(continued)*

Implemented ([redacted] - 08/07/2025)

133.1 - Exit Signs

5. Requirements

2600.
133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word ''EXIT'' in plain legible letters shall be placed at all exits.

Description of Violation

There is no signage indicating whether or not the door between the E-wing and ramp to secured dementia care unit (SDCU) is an emergency exit. The home currently serves 39 residents.

Plan of Correction ***Accept ([redacted] - 08/06/2025)***

1. Maintanence Director placed no exit signage on the door on 6/23/2025 as immediate corrective measure.
2. Maintanence Director audited all doors on 6/24/2025 for corrective signage to measure overall compliance.
3. The Administrator educated all staff on 6/26/2025 on regulation 2600.133.1. Documentation will be kept on file.
4. Maintenance and/or designee will audit all doors for correct signage starting 7/1/2025 twice a month for three months to measure ongoing compliance. Documentation will be kept on file and reviewed at monthly QA meetings starting August 2025.

Licensee's Proposed Overall Completion Date: *08/06/2025*

Implemented ([redacted] - 08/07/2025)

183b - Meds and Syringes Locked

6. 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

At approximately 2:00 p.m., [redacted] were unlocked, unattended, and accessible on the bedside table in resident #4's bedroom.

Plan of Correction ***Accept ([redacted] - 08/06/2025)***

1. Medication was removed from the residents room on 6/23/2025 by the Administator and placed in the medication cart and Medication tech was re-educated one on one by the Medication tech trainer as immediate corrective action.
2. On 6/24/2025 two Observations completed by the Medication tech trainer on Medication Tech by the that left the medication in the room to ensure competence and compliance.
3. The Administrator completed a whole house audit of unsecured medications on 6/24/2025 to measure overall compliance.
4. All staff reeducated on 626/2026 on regulation 2600.183.b and Medication Administration policy and procedures.
5. Administrator and/or designee will audit that all medications are secure starting 7/1/2025 weekly for two months to measure ongoing compliance. Documentation will be kept on file and reviewed at the monthly QA meeting

183b - Meds and Syringes Locked (continued)

beginning August 2025.

Licensee's Proposed Overall Completion Date: *08/26/2025*

Implemented ([redacted] - 08/07/2025)

184a - Resident's Meds Labeled

7. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

The pharmacy label for resident #5's medication indicates Warfarin 7.5mg, take 1 tablet Monday, Wednesday, Friday & Warfarin 5mg, take 1 tablet Sunday, Tuesday, Thursday, Saturday; however, the prescription was changed on 6/10/25 to Warfarin 7.5mg, take 1 tablet on Sunday, Tuesday, Thursday, Saturday & Warfarin 5mg, take 1 tablet on Monday, Wednesday, Friday.

Repeat Violation: 5/30/2024

Plan of Correction ***Accept ([redacted] - 08/06/2025)***

1. Medication change in direction label applied to medication on 6/23/2025 as immediate corrective measure.
2. Administrator completed all med cart audit on 6/25/2025 to measure compliance.
3. All staff educated by Administrator on 6/26/2025 of medication administration policy and regulation 2600.184.a..
4. Administrator and/or designee will audit all medication carts to check medication labels againts MAR's starting 7/14/2025 monthly for three months.for ongoing compliance. Documentation will be kept and reviewed at the monthly QA meeting beginning August 2025.

Licensee's Proposed Overall Completion Date: *08/06/2025*

Implemented ([redacted] - 08/07/2025)

187a - Medication Record

8. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.

187a - Medication Record *(continued)*

8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #5 is prescribed Aspirin 81mg, Carbidopa Levodopa 25mg-100mg, Methazolamide 50mg, Midodrine 10mg, & Primidone 250mg. However, the resident's June 2025 medication administration record (MAR) does not indicate diagnosis or purpose.

Resident #6 is prescribed Citalopram 10mg, Oxcarbazepine 150mg, Quetiapine 25mg, Atorvastatin 20mg, Oxcarbazepine 300mg & Quetiapine 100mg. However, resident's June 2025 MAR record does not indicate diagnosis or purpose.

Plan of Correction ***Accept ([redacted] - 08/06/2025)***

1. Administrator called pharmacy on 6/23/2025 and had the diagnosis that fell off of Emar added on 6/23/2025 as pharmacy adds our order and diagnosis to emar as immediate corrective action.
2. Administrator completed a whole house audit of emar to ensure diagnosis is showing on Emar on 6/24/2025 to measure compliance.
3. Administartaor completed additional audit of Emar on 6/25/2025 to ensure the diagnosis were showing on Emars that were missing diagnosis. to measure overall compliance.
4. Administrator educated all staff on 6/24/2025 on regulation 2600.187.a.
5. Administrator and or/designee will audit all Emar's beginning 7/14/2025 monthly for three months to measure ongoing compliance. Documentation will be kept on file and reviewed at the monthly QA meetings beginning August 2025.

Licensee's Proposed Overall Completion Date: *08/06/2025*

Implemented ([redacted] - 08/07/2025)

187d - Follow Prescriber's Orders

9. Requirements

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

Description of Violation

Resident #6 is prescribed Albuterol Sulfate 90mcg as needed & Naproxen 250mg as needed; however, these medications were not available in the home.

Plan of Correction ***Accept ([redacted] - 08/06/2025)***

1. The Administrator called pharnmacy on 6/23/2025 and re-ordered the PRN medications that were not in the medication cart as immediate corrective action.
2. The Administrator completed a whole house audit on medication carts on 6/24/2025 to measure compliance.
3. The Administartor educated all staff on 6/26/2025 on policy and procedure for reordering of medication regulation 2600.187.d.
4. The Administrator and/or designee will audit all medication carts begininng 7/14/2025 monthly for three

187d - Follow Prescriber's Orders (continued)

months to measure ongoing compliance. Documentation will be kept on file and reviewed at the monthly QA meetings beginning August 2025.

Licensee's Proposed Overall Completion Date: *08/06/2025*

Implemented (- 08/07/2025)

234b - Support Plan Needs Elements

10. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan, dated , for resident #7 does not address the following needs: Hospice services, which began on 5; alarms, both a chair sensor / bed sensor, which began on ; a Hoyer lift as needed for fatigue and weakness, which began on ; and an adult adaptive cup (sippy cup) during meals and as needed which began on

Plan of Correction ***Accept (- 08/06/2025)***

1. The Administrator corrected the support plan and added the missing care needs on 6/23/2025 as immediate corrective measure.
2. The Administrator completed a whole house audit of all support plans on 6/25/2025 to measure compliance.
3. The Administrator educated the Resident Services Director and all staff on 6/25/2025 on regulation 2600.234.b.
4. The Administrator and/or designee will audit all support plans begininng 7/14/2025 monthly for three months to measure ongoing compliance. Documentation will be kept on file and reviewed at the monthly QA meetings beginning August 2025.

Licensee's Proposed Overall Completion Date: *08/06/2025*

Implemented (- 08/07/2025)