

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

October 29, 2025

[REDACTED]
GRACEFUL CARE LIVING, LLC

[REDACTED]
SUITE 100
[REDACTED]

RE: GRACEFUL CARE LIVING
211 GARNIER STREET
SHARPSBURG, PA, 15215
LICENSE/COC#: 45467

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/21/2025 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: GRACEFUL CARE LIVING	License #: 45467	License Expiration: 07/10/2025
Address: 211 GARNIER STREET, SHARPSBURG, PA 15215		
County: ALLEGHENY	Region: WESTERN	

Administrator		
Name: [REDACTED]	Phone: [REDACTED]	Email: [REDACTED]

Legal Entity		
Name: GRACEFUL CARE LIVING, LLC		
Address: [REDACTED]		
Phone: [REDACTED]	Email: [REDACTED]	

Certificate(s) of Occupancy		
Type: C-2 LP	Date: 03/08/1996	Issued By: Dept. of L and I

Staffing Hours		
Resident Support Staff: 0	Total Daily Staff: 31	Waking Staff: 23

Inspection Information		
Type: Partial	Notice: Unannounced	BHA Docket #:
Reason: Complaint, Provisional, Incident, Interim		Exit Conference Date: 07/21/2025

Inspection Dates and Department Representative	
07/21/2025 - On-Site	[REDACTED]

Resident Demographic Data as of Inspection Dates			
General Information			
License Capacity: 52		Residents Served: 24	
Secured Dementia Care Unit			
In Home: No	Area:	Capacity:	Residents Served:
Hospice			
Current Residents: 10			
Number of Residents Who:			
Receive Supplemental Security Income: 1		Are 60 Years of Age or Older: 22	
Diagnosed with Mental Illness: 10		Diagnosed with Intellectual Disability: 3	
Have Mobility Need: 7		Have Physical Disability: 0	

Inspections / Reviews		
07/21/2025 Partial		
Lead Inspector: [REDACTED]	Follow-Up Type: POC Submission	Follow-Up Date: 08/29/2025
09/04/2025 - POC Submission		
Submitted By: [REDACTED]	Date Submitted: 08/29/2025	
Reviewer: [REDACTED]	Follow-Up Type: POC Submission	Follow-Up Date: 09/10/2025

Inspections / Reviews (*continued*)

09/19/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/10/2025

Reviewer: [REDACTED]

Follow Up Type: *Bypass Document
Submission*

10/29/2025 Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/19/2025

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

On [REDACTED], at approximately 10:05 am, the sliding door for the office/storage area in the lobby was unlocked. There were no staff members in the office or lobby. Multiple resident records were on the floor in the office including: --The entire record of discharged resident [REDACTED] including a medical evaluation, assessment/support plan and physician orders/medication lists. --Hospital records, blood work results and a medication list for resident [REDACTED]

Plan of Correction

Accept [REDACTED] - 09/02/2025)

Correction was made that the administrator's office door (the area referred to in the description of the violation) is secured with a new numerical coded lock installed by maintenance staff [REDACTED] on 8/26/2025. Only the administrator/owner [REDACTED] and supervisors [REDACTED] and [REDACTED] are privy to the code. Administrator/owner [REDACTED] re-educated all staff members on 8/26/2025 that all resident records shall be kept secured and confidential as stated under 2600.17 guidelines. Documented once weekly checks checks for 6 months was implemented on 6/25/2025 to ensure that resident records are secured and inaccessible. These checks are performed by either of which the administrator/owner [REDACTED] and supervisors [REDACTED] and [REDACTED]. Documentation will be kept in accordance with regulation 2600.65(i). Please see attached documentation.

Licensee's Proposed Overall Completion Date: 08/29/2025

Implemented [REDACTED] - 09/23/2025)

85a - Sanitary Conditions

3. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On [REDACTED] at 10:25 a.m., feces were observed covering the toilet seat, splattered on both the front and back of the toilet, and on the removable splash guard in the bathroom adjacent to bedroom [REDACTED]. Feces were also smeared on the floor in front of the toilet.

Repeat Violation: [REDACTED] et al

Plan of Correction

Directed [REDACTED] - 09/11/2025)

Administrator [REDACTED] is disputing this violation and requesting that it is withdrawn due to sanitary conditions within the facility are maintained. Staffing does not permit for someone to be posted outside of each bathroom and verify that all bathrooms are clean and sanitary in between resident use. The facility has a scheduled housekeeper on staff 5 to 6 days on a weekly basis. Upon discovery of the apparent fecal matter on the one toilet referred to in this violation, it was immediately cleaned and disinfected by the housekeeper on shift [REDACTED]. Administrator/owner [REDACTED] and/or

85a - Sanitary Conditions (continued)

supervisors [redacted] and [redacted] does due diligence by performing weekly documented bathroom checks (implemented on 11/25/2024 and are still being completed) which include verifying for cleanliness. On 8/26/2025 administrator [redacted] re-educated all staff on 2600.85.(a) to re-iterate sanitary conditions. Documentation of this education will be kept on file in accordance with 2600.65.(i). Please see attached documentation.

Starting 9/10/2025, administrator/owner [redacted] and/or supervisors [redacted] and [redacted] along with housekeeper [redacted], maintenance [redacted] and on shift DCS will perform 2 documented checks per shift daily for six months on facility bathrooms (hourly checks is not feasible and could hinder resident care and supervision) which include verifying for cleanliness. All documentation will be kept on file within the facility for the department to verify.

DIRECTED: Within 5 days of receipt of the plan of correction - The administrator or a designee will conduct monitoring at least 5 times daily on the identified bathroom where the violation occurred, to ensure it is kept in a sanitary condition. - [redacted] 9/11/25

Directed Completion Date: 09/17/2025

Implemented ([redacted] - 09/23/2025)

85b - Infestation

4. Requirements

2600.

85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

There were innumerable mouse droppings in various areas throughout the house as follows:

- Floor of the storage room at the end of the hall by the elevator on the 4th floor
- Mattress, bedding and windowsill on the left side of room [redacted]
- Closet floor of unoccupied room [redacted]
- Covering the mattress and box springs of unoccupied room [redacted]

On [redacted], at 10:42 am, there were 4 live bed bugs, dead bed bugs and bed bug castings at the seams in 2 fabric couches against the long wall across from the TV in the living room. According to the 3 residents sitting on a chair or in their wheelchairs in the living room, they cannot sit on the couches because of the bugs.

Plan of Correction

Accept ([redacted] - 09/11/2025)

Administrator/owner along with the other owners have implemented in 2023 monthly and as needed treatments and removal for pests and rodents by contracting Orkin to service the facility currently and ongoing. Staff is and due diligently reports any and all evidence of pests, including bed bugs and mice within the facility. The floor of the storage room at the end of the hall by the elevator on the 4th floor, the mattress, bedding and windowsill on the left side of room [redacted], the closet floor of unoccupied room [redacted], and the mattress and box springs of unoccupied room [redacted] was again cleaned by maintenance staff [redacted] on 8/19/2025. On 8/26/2025 administrator [redacted] re-educated all staff on 2600.85(b) to re-iterate what the factors are of a potential infestation and to continue to immediate report

85b Infestation (continued)

any evidence thereof. Administrator/owner [redacted] and/or supervisors [redacted] and [redacted] does due diligence by performing once weekly documented checks for 6 months of the facility that includes the common areas, bedrooms and storage areas to ensure that there is no evidence of any type of infestation. If any evidence is observed, [redacted] will immediately contact Orkin to treat the areas in question so that further issues related to an infestation does not occur. Attached to this plan of correction is the contact information of the Orkin representative who services and is familiar with this facility to verify that treatments and all due diligence is being done. Documentation of this education will be kept on file in accordance with 2600.65.(i). Please see attached documentation.

As administrator/owner [redacted] explained to department inspectors [redacted] and [redacted] during the reinspection of this LIS, the living room couches were replaced with new couches in April 2025, (any furniture that was sought to be infested were immediately disposed of which included, but not limited to, 2 couches, 3 armchairs, several mattresses, and 3 bed frames) and have since been treated during the contracted bi weekly and as needed treatments performed by Orkin. Orkin is a reputable company and is deemed the best company to utilize for both pest and rodent removal and preventative measures. The managing partners did also have Fox Pest Control and Extermination treat the facility and learned that they were owned by Orkin and used the same products. Reason why the owners just opted to continue to utilize Orkin for service. The most frequent treatments are being done and have been since fall 2023. The residents were asked not to sit on the couches 1 2 hours post treatments due to the chemicals used per Orkin recommendation, not because of any type of infestation. This was also explained by admin/owner [redacted] to on site inspectors during the reinspection of this LIS. Please refer to the previously attached documentation.

Licensee's Proposed Overall Completion Date: 09/09/2025

Implemented [redacted] - 09/23/2025)

92 - Windows

5. Requirements

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On [redacted] from approximately 8:30 am to 10:10 am, the front door was propped open. There was no screen in the doorway. In addition, one of the stained glass windows in the lobby was open with no screen in place.

On [redacted] at 9:50 am there were open gaps on each side of the window air conditioner in room [redacted]. The open areas measured approximately 1.5. inches wide by 12 inches long.

Plan of Correction

Accept [redacted] - 09/02/2025)

Administrator/owner [redacted] closed the front door upon arrival to the facility. A sign was placed on the door by supervisor JM that states 'PLEASE KEEP DOOR CLOSED AT ALL TIMES, DO NOT PROP OPEN' on 8/26/2025. The decorative stained glass windows in the lobby were sealed on 8/28/2025 by maintenance staff [redacted] as per department inspectors [redacted] and [redacted] told admin/owner [redacted] during the inspection that they did not require a screen as long as they could not be opened. On 7/23/2025, the window air conditioning unit was removed in [redacted] the screen was replaced and the interior air conditioning unit was repaired by staff member [redacted]. Administrator/owner [redacted] and/or supervisors [redacted] and [redacted] performs weekly documented checks implemented 8/26/2025 for 6 months that doors are not propped and screens in windows are in place. On 8/26/2025 administrator [redacted] re educated all staff on 2600.92 to re iterate that doors must remain closed/not propped open and that screens are to be secured in the windows. Documentation of

92 Windows (continued)

this education will be kept on file in accordance with 2600.65.(i). Please see attached documentation.

Licensee's Proposed Overall Completion Date: 08/29/2025

Implemented [redacted] - 10/22/2025)

185a - Implement Storage Procedures

7. 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 [redacted] is ordered [redacted], inject subcutaneously 3 times a day with meals per sliding scale: 70 140 0 units; 141 180 2 units; 181 220 4 units; 221 260 6 units; 261 300 8 units; 301 340 10 units; >340 12 units and call [redacted].

Resident [redacted]'s glucometer reading was [redacted] at 12:27 pm on 7/17/2025, but a reading of [redacted] was entered on [redacted] July medication administration record (MAR).

Resident [redacted] glucometer reading was [redacted] at 4:04 pm on 7/20/2025, but no reading was entered on [redacted] July medication administration record.

Resident [redacted] is ordered [redacted], inject subcutaneously 3 times daily before meals per sliding scale: 150 199 5 units; 200 249 7 units; 250 299 9 units, 300 399 12 units.

Resident [redacted] blood glucose readings were recorded incorrectly on the MAR on the following dates and times: glucometer indicated [redacted] at 8:02 am on 7/16/2025, but [redacted] was entered on the MAR glucometer indicated [redacted] at 4:16 pm on 7/18/2025, but [redacted] was entered on the MAR glucometer indicated [redacted] at 11:46 am on 7/19/2025, but [redacted] was entered on the MAR

Repeat Violation: [redacted]

Plan of Correction

Accept [redacted] 09/04/2025)

Administrator [redacted] re educated med trained staff on the requirements of 2600.185.(a) on 8/26/2025 along with the policies and procedures that coincide with this regulation. Administrator [redacted] and designated persons [redacted] (supervisor) and [redacted] (med tech) are to complete documented once weekly MAR/medication cart audits for 6 months which include glucometer checks and accurate documentation. Administrator [redacted] implemented this audit including glucometer checks on 8/26/2025 once weekly for 6 months. Annual diabetic training was completed by [redacted] a licensed CDE on 4/7/2025 with documentation on file. Documentation of this education will be kept on file in accordance with 2600.65(i). Please see attached documentation

Licensee's Proposed Overall Completion Date: 08/29/2025

Implemented [redacted] - 09/23/2025)

187a - Medication Record

8. Requirements

187a - Medication Record (continued)

2600.

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

6. Dose.

Description of Violation

Resident [redacted] is ordered [redacted], inject subcutaneously 3 times a day with meals per sliding scale: 70-140= 0 units; 141-180=2 units; 181-220=4 units; 221-260=6 units; 261-300=8 units; 301-340=10 units; >340=12 units and call [redacted]

On [redacted] at 4:04 p.m., resident # [redacted] had a glucometer reading of [redacted], which required 2 units of [redacted] however, according to [redacted] MAR, no [redacted] was administered.

Resident [redacted] is ordered [redacted], inject subcutaneously 3 times daily before meals per sliding scale: 150-199=5 units; 200-249=7 units; 250-299=9 units, 300-399=12 units. According to the July medication administration record (MAR), on [redacted] before dinner, resident [redacted] had a glucometer reading of [redacted], which required [redacted]; however, the resident # [redacted] was administered [redacted].

Repeat Violation: [redacted] et al

Plan of Correction

Accept ([redacted] 09/04/2025)

Administrator [redacted] re-educated med trained staff on the requirements of 2600.187.(a) on 8/26/2025 along with the policies and procedures that coincide with this regulation. Administrator [redacted] and designated persons [redacted] (supervisor) and [redacted] (med tech) are to complete documented once weekly MAR/medication cart audits for 6 months which include glucometer checks and accurate documentation. Administrator [redacted] implemented this audit including glucometer checks on 8/26/2025 once weekly for 6 months. Annual diabetic training was completed by [redacted] a licensed CDE on 4/7/2025 with documentation on file. Documentation of this education will be kept on file in accordance with 2600.65(i). Please refer the attached documentation uploaded under 2600.185(a)

Licensee's Proposed Overall Completion Date: 08/29/2025

Implemented [redacted] - 09/23/2025)