pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ERIE OPS LLC**
LEGAL ENTITY

To operate **WESTLAKE WOODS AL**
NAME OF FACILITY OR AGENCY

Located at **3302 WEST LAKE ROAD, ERIE, PA 16505**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Assisted Living**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **79**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

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

55 Pa.Code Chapter 2800: Assisted Living Residences
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **December 10, 2025** until **June 10, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **454072**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: DECEMBER 10, 2025

[redacted]
Erie OPS LLC
[redacted]

RE: Westlake Woods AL
3302 West Lake Road
Erie, Pennsylvania 16505
License/COC #: 454072

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on May 12, 2025, June 3, 2025, June 4, 2025, July 29, 2025, July 30, 2025, August 7, 2025, September 4, 2025, September 12, 2025, November 6, 2025 and November 7, 2025 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) ;(5) and 55 Pa. Code § 20.71(a)(2) ; (3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from DECEMBER 10, 2025 to JUNE 10, 2026.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2800 (relating to enforcement), the Department intends to assess a fine for the following violations unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2800 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
23(a)	II	40	$5	$200	5 calendar days from Mailing date of this letter
42(b)	II	40	$5	$200	5 calendar days from Mailing date of this letter
65(g)	III	40	$3	$120	15 calendar days from mailing date of this letter
81(b)	II	40	$5	$200	5 calendar days from Mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a SECOND PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your SECOND PROVISIONAL license, a written request for an appeal must be received within 30 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street

Harrisburg, Pennsylvania 17120
PH: 717-265-8942

This decision is final 31 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

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

Facility Information

Name: *WESTLAKE WOODS AL* **License #:** *45407* **License Expiration:** *10/31/2025*

Address: *3302 WEST LAKE ROAD, ERIE, PA 16505*

County: *ERIE* **Region:** *WESTERN*

Administrator

Name: [redacted]

Legal Entity

Name: *ERIE OPS LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *10/31/1997* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *58* **Waking Staff:** *44*

Inspection Information

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

Reason: *Complaint, Incident, Fine* **Exit Conference Date:** *05/19/2025*

Inspection Dates and Department Representative

05/12/2025 - On-Site: [redacted]
05/15/2025 - Off-Site:
05/16/2025 - Off-Site:
05/19/2025 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *79* **Residents Served:** *42*

Special Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *42*

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

Have Mobility Need: *16* **Have Physical Disability:** *2*

Inspections / Reviews

05/12/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/02/2025*

06/16/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/11/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/11/2025*

10/15/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *07/11/2025*

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

15a Resident abuse report

1. Requirements

2800.
15.a. The residence shall immediately report suspected abuse of a resident served in the residence in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted]25, at approximately 4:00 a.m., staff persons A & B were assisting resident #1 in bed and hit the resident's head off the wall. This incident was observed by staff person C. This incident was reported to multiple staff persons later that day. However, this allegation of abuse was not reported to the local Area Agency on Aging until 5/9/25.

Repeat Violation: 1/9/25 et al.

Plan of Correction ***Accept [redacted] - 06/16/2025)***

The Executive Director (ED) or designee provided training on mandated reporting procedures to staff on 5/30/2025. By 6/19/2025, 100% of staff will be trained on the prompt identification and immediate reporting of suspected abuse in accordance with the Older Adult Protective Services Act and 6 Pa. Code § 15.21–15.27. Training content includes recognizing abuse, the requirement to report immediately, and proper documentation and communication procedures. Documentation of completed training will be maintained in staff files per regulation 2800.65(l).
To prevent recurrence, the ED or designee will ensure that all new hires receive mandated reporter training as part of onboarding and that all employees complete refresher training annually. A training tracker will be used to monitor due dates and completion status.
To support ongoing compliance, the ED or designee will audit five employee training files weekly for four consecutive weeks to confirm completion of mandated reporting training. Audits will continue until compliance is achieved. Additionally, the ED or designee will conduct a daily review of all internal incident reports to ensure timely reporting to the Area Agency on Aging (AAA) when abuse is suspected. These reviews will be logged and retained for quality assurance. Audits will be reviewed during the next monthly Quality Assurance meeting no later than July 8, 2025.

Licensee's Proposed Overall Completion Date: *07/08/2025*

Evidence of Completion ***Not Implemented [redacted] - 10/15/2025)***

See attached.

15b Resident abuse-superv plan

2. Requirements

2800.
15.b. If there is an allegation of abuse of a resident involving a residence's staff person, the residence shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On [redacted]25, at approximately 4:00 a.m., staff persons A & B were assisting resident #1 in bed and hit the resident's head off the wall. This incident was observed by staff person C. This incident was reported to multiple staff persons later that day. Staff persons A & B continued to work in the residence until 5/9/25.

On [redacted]/25, at approximately 9:00 a.m., there was an allegation that staff person D had shoved resident #2 when the resident was attempting to walk out the front door of the residence. This incident was reported to staff person E, the residence's [redacted], that day. However, staff person D continued to work in the residence, and was not

15b Resident abuse-superv plan (continued)

suspended nor placed on a plan of supervision.

Plan of Correction ***Accept[redacted] - 06/16/2025)***

Staff Persons A and B were immediately [redacted]d on [redacted] 2025 following the allegation of abuse, in compliance with regulation 2800.15(b). The incident was reported to the Department of Human Services and Adult Protective Services the same day. After investigation, both employees were t[redacted] for failure to follow internal abuse prevention and reporting policies.

To prevent recurrence, the Area Director of Operations (ADO) will ensure that all new Executive Directors (EDs) receive training on abuse reporting requirements under 2800.15(b) during their onboarding process. Additionally, all current staff will complete refresher training on mandated reporting and the requirement to immediately suspend or supervise staff involved in alleged abuse. This training will be completed by June 19, 2025, and documented per regulation 2800.65(l).

To monitor compliance, the ED or designee will conduct weekly audits of incident reports to verify that appropriate action (i.e., suspension or supervision) was taken immediately in any abuse allegation involving a staff person. These audits will be reviewed during Quality Assurance meetings. The next Quality Assurance meeting is scheduled for no later than July 8, 2025.

Licensee's Proposed Overall Completion Date: *07/08/2025*

Evidence of Completion ***Not Implemented[redacted] - 10/15/2025)***

See attached.

16c Incident reporting

3. Requirements

2800.

16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted]/25, at approximately 4:00 a.m., staff persons & B were assisting resident #1 in bed and hit the resident's head off the wall. This incident was observed by staff person C. This incident was reported to multiple staff persons later that day. The residence did not report this incident to the Department until 5/9/25.

Repeat Violation: 1/9/25 et al., 11/22/2024

Plan of Correction ***Accept[redacted] - 06/16/2025)***

The Executive Director (ED) or designee will provide re-training to all staff by June 19, 2025, on the requirements for timely reporting of incidents, changes in condition, and suspected maltreatment. This training will review the residence's internal accident, incident, change in condition, and maltreatment policies, emphasizing the requirement to notify the Department within 24 hours and to follow the abuse reporting procedures outlined in § 2800.15.

To prevent recurrence, the ED or designee will integrate mandatory incident reporting education into new hire orientation and ensure refresher training is conducted annually for all staff. Training records will be maintained in accordance with regulation 2800.65(l).

To monitor ongoing compliance, beginning June 9, 2025, the ED or designee will conduct weekly audits of incident and change of condition reports for four consecutive weeks to verify that reporting to the Department occurred within 24 hours when required. Audits will continue until compliance is achieved. Findings from these audits will be discussed during the Quality Assurance meeting following the audit period. The next Quality Assurance meeting is

16c Incident reporting (continued)

scheduled for no later than July 8, 2025.

Licensee's Proposed Overall Completion Date: *07/08/2025*

Evidence of Completion ***Not Implemented [redacted] 10/15/2025)***

See attached.

42b Abuse/Neglect

4. Requirements

2800.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted]/25 at approximately 4:00 a.m., staff person A & B were assisting resident #1 in bed and hit the resident's head on the wall. This was observed by staff person C and reported to multiple staff persons later that day. The next day, resident #1 was being assisted by staff in [redacted] bed and the resident asked if [redacted] head was broken, and later that morning the resident was observed with an approximate 3-inch red mark on [redacted] forehead.

Repeat Violation: 1/9/25 et al., 11/22/24

Plan of Correction ***Accept[redacted] - 06/16/2025)***

The Executive Director (ED) will reinforce the community's abuse prevention policy with all staff, reiterating that residents have the right to be free from abuse, neglect, intimidation, and mistreatment by June 19, 2025. Documentation of the training is maintained. Any violations of this policy result in immediate investigation and appropriate disciplinary action, up to and including termination.
To prevent recurrence, the ED or designee will check in with five randomly selected residents each week for four consecutive weeks to ask about service satisfaction and any concerns related to safety or treatment. These check-ins will be documented, and follow-up actions will be taken when concerns are identified. Resident feedback will be logged and reviewed during the next Quality Assurance meeting no later than July 8, 2025.
The ED or designee will also continue to provide education on resident rights and abuse prevention to all new hires during orientation, with documentation maintained in accordance with regulation 2800.65(l). Weekly audits of training records will be conducted for four weeks to verify that abuse prevention training is completed at hire and annually for all team members. Audits will continue until compliance is achieved.

Licensee's Proposed Overall Completion Date: *07/08/2025*

Evidence of Completion ***Not Implemented [redacted] - 10/15/2025)***

See attached.

42c Dignity/Respect

5. Requirements

2800.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [redacted]/25, resident #2 moved into the residence from an independent retirement community. However, on multiple occasions, resident #2 attempted to leave the residence, including the following, resulting in an incident

42c Dignity/Respect (continued)

resident and staff:
On [redacted]/25, at approximately 5:30 p.m., resident #2 was trying to leave the residence stating it was a prison, threating to break windows, and screaming for the police to be called. The staff called the police and sent the resident to the hospital requesting an involuntary mental health commitment. The hospital sent the resident back to the residence the same day and denied the commitment.
On [redacted]/25, at approximately 3:30 p.m., resident #2 was trying to leave the residence, shoving through the staff to try and go through the front doors. Resident #2 was visibly agitated, stating [redacted] was going to break the glass on the doors to get out, and began throwing objects in the lobby. The staff called the police and sent the resident to the hospital, again, requesting an involuntary mental health commitment. The hospital sent the resident back to the residence the same day and denied the commitment.
On [redacted]/25, at approximately 9:00 a.m., resident #2 was trying to leave the residence, partially opening the front door, shoving staff to exit through the front doors of the residence, and stating it was a prison. The staff stood in front of the resident preventing the resident from leaving. The resident was eventually redirected back to sit down in the common area.
On [redacted]/25, resident #2's [redacted] discharged the resident from the residence and moved resident #2 back to the independent retirement community.

Repeat Violation: 1/9/25 et al.

Plan of Correction ***Accept[redacted] 06/16/2025)***

The Executive Director (ED) or designee will provide in-service training to all staff on resident rights, with a focus on promoting dignity, respect, and person-centered care. This training will be completed by June 19, 2025, and documentation will be maintained in accordance with regulation 2800.65(l).
To prevent recurrence, the ED or designee will incorporate resident rights education, including treating all residents with dignity and respect, into new hire orientation. This training will be reinforced annually for all staff to ensure continued compliance and culture alignment.
To monitor ongoing compliance, the ED or designee will conduct weekly audits of staff training records for four consecutive weeks, beginning the week of June 9, 2025, to verify that resident rights training has been completed upon hire and annually. Audits will continue until compliance is achieved. Findings will be reviewed during Quality Assurance meetings, and corrective actions will be taken as necessary. The next Quality Assurance meeting is scheduled no later than July 8, 2025.

Licensee's Proposed Overall Completion Date: *07/08/2025*

Evidence of Completion ***Not Implemented [redacted] - 10/15/2025)***

See attached.

54a Direct care staff quals

6. Requirements

2800.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff persons A, B & C do not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

54a Direct care staff quals (continued)

Repeat Violation: 1/9/25 et al.

Plan of Correction ***Accept [redacted] - 06/16/2025)***

The Area Director of Operations (ADO) or designee provided training to the Executive Director (ED) on June 5, 2025, regarding the qualification requirements outlined in regulation 2800.54(a)(2). The training covered acceptable documentation for verifying high school diplomas, GEDs, or active nurse aide registry status. Documentation of this training is maintained on file.

To prevent recurrence, the ED or designee will ensure that all new hires in direct care positions provide proof of the required qualifications before starting employment utilizing the New Hire Checklist. This will be verified during the hiring process and documented in each employee's personnel file.

To monitor compliance, beginning the week of June 9, 2025, the ED or designee will audit five direct care staff files weekly for four consecutive weeks to verify that the required educational documentation or registry status is present and appropriately filed. Any discrepancies identified will be immediately addressed. Audits will continue until compliance has been achieved. Audits will be reviewed during the next Quality Assurance meeting, no later than July 8, 2025

Licensee's Proposed Overall Completion Date: *07/08/2025*

Evidence of Completion ***Implemented ([redacted] - 10/15/2025)***

See attached.

201 Positive interventions

7. Requirements

2800.

201. Safe Management Techniques - The residence shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Resident #2 has attempted to leave the residence multiple times resulting in an altercation between the resident and staff and requiring assistance with police and EMS services. When the resident attempted to leave, multiple staff use their bodies to blockade the exit causing the resident to become increasingly agitated and violent. The residence has not implemented positive interventions to modify or eliminate the behavior.

Plan of Correction ***Accept [redacted] - 06/16/2025)***

The Executive Director (ED) or designee will provide retraining to all staff on the use of Safe Management (Behavioral Expressions) techniques by June 19, 2025. This training will include education on positive interventions such as de-escalation, redirection, communication strategies, and behavior reinforcement, in accordance with regulation 2800.201. Documentation of this training will be maintained in each employee's training file per regulation 2800.65(l).

To prevent recurrence, Safe Management (Behavioral Expressions) techniques will be incorporated into the onboarding process for all new hires and included in annual staff training. Ongoing emphasis will be placed on person-centered care approaches to behavioral management.

201 Positive interventions (continued)

To ensure compliance, beginning the week of June 9, 2025, the ED or designee will audit five employee files weekly for four consecutive weeks to verify that Safe Management training was completed and documented. Audit findings will be discussed during the next Quality Assurance meeting, no later than July 8, 2025.

Licensee's Proposed Overall Completion Date: *07/08/2025*

Evidence of Completion ***Implemented [redacted] - 10/15/2025)***

See attached.

202 Prohibitions

8. Requirements

2800.
202. The following procedures are prohibited:
6. A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompting, escorting or guiding a resident to assist in the ADLs or IADLs.

Description of Violation

On [redacted]/25, at approximately 5:30 p.m., on [redacted]/25, at approximately 3:30 p.m., and on [redacted]25 at approximately 9:00 a.m., resident #2 was attempting to leave the residence. Multiple staff persons, including staff person D, prohibited the resident from leaving by physically blocking a doorway to prevent resident egress.

Plan of Correction ***Accept [redacted] - 06/16/2025)***

The Executive Director (ED) or designee will provide retraining to all staff on prohibited procedures, including the prohibition of manual restraints, by June 19, 2025. The training will emphasize acceptable techniques such as escorting, prompting, and guiding, as well as reinforce the importance of using only approved, non-restrictive methods for managing behaviors and supporting activities of daily living. Training will be documented and maintained in accordance with regulation 2800.65(l).
To prevent recurrence, the ED or designee will ensure this topic is included in the mandatory orientation training for all new staff and reviewed annually during competency refreshers. Staff will also be educated on recognizing and reporting any unauthorized physical interventions.
To monitor compliance, beginning June 9, 2025, the ED or designee will audit five staff training records weekly for four consecutive weeks to confirm the completion of training on Safe Management (Behavioral Expressions) techniques and prohibited practices. Findings will be reviewed during Quality Assurance meetings and appropriate corrective action taken if noncompliance is identified. The next Quality Assurance meeting is scheduled for no later than July 8, 2025.

Licensee's Proposed Overall Completion Date: *07/08/2025*

Evidence of Completion ***Implemented [redacted] - 10/15/2025)***

See attached.

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

Facility Information

Name: *WESTLAKE WOODS AL* **License #**: *45407* **License Expiration**: *10/31/2025*

Address: *3302 WEST LAKE ROAD, ERIE, PA 16505*

County: *ERIE* **Region**: *WESTERN*

Administrator

Name: [redacted]

Legal Entity

Name: *ERIE OPS LLC*

Address: [redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *52* **Waking Staff**: *39*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *06/04/2025*

Inspection Dates and Department Representative

06/03/2025 - On-Site: [redacted]
06/04/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *79* **Residents Served**: *40*

Special Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *40*

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

Have Mobility Need: *12* **Have Physical Disability**: *2*

Inspections / Reviews

06/03/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/26/2025*

Inspections / Reviews *(continued)*

06/26/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/25/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/18/2025*

11/19/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/18/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

15a Resident abuse report

1. Requirements

2800.

15.a. The residence shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

According to multiple staff interviews, on [redacted]/25 at approximately 8:30 a.m., resident #1 was standing in the doorway of the administrator's office speaking to direct care staff A, the [redacted]. Resident #1 was standing with [redacted] right hand on [redacted] walker and [redacted] left hand on the door frame, when direct care staff A abruptly ended the conversation and slammed the door, pinching the resident's left 4th finger between the door and frame and causing the resident to fall backwards and hit [redacted] head. Direct care staff A opened the door and asked "What happened?" and the resident replied "You slammed the door on my finger!" Resident #1 was very upset and in a great deal of pain. The home's nursing staff administered first aid and called for an ambulance which transported the resident to the hospital for treatment where [redacted] was diagnosed with an open fracture of tuft of distal phalanx and a laceration requiring ten sutures.

The residence failed to report this incident to the local area agency on aging until 6/4/25.

Repeat Violation: 1/9/25 et al.

Plan of Correction ***Accept [redacted] - 06/26/2025)***

The Executive Director (ED) immediately reported the incident involving Resident #1 to the local Area Agency on Aging (AAA) on June 4, 2025, once it was brought to their attention. Direct care staff A, who was involved in the incident, was [redacted] immediately pending investigation. All appropriate internal documentation was completed and maintained.

To mitigate recurrence, the ED or designee will initiate re-education to all staff on mandated reporting requirements starting June 25, 2025, with emphasis on the obligation to report immediately and the definition of suspected abuse. The training will include review of the Older Adult Protective Services Act and internal procedures for reporting to the AAA. Documentation of training will be maintained in accordance with regulation 2800.65(l).

To support ongoing compliance, the ED or designee will review all incident and injury reports daily for a period of 30 days, beginning June 17, 2025, to verify any suspected abuse is immediately reported to the appropriate authorities. A log of reporting timelines will be maintained and reviewed during the next Quality Assurance and Improvement Program (QAIP) meeting, no later than July 9, 2025.

Licensee's Proposed Overall Completion Date: *07/09/2025*

Evidence of Completion ***Not Implemented [redacted] - 10/15/2025)***

See attached.

16c Incident reporting

2. Requirements

2800.

16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

16c Incident reporting *(continued)*

Description of Violation

According to multiple staff interviews, on [redacted]/25 at approximately 8:30 a.m., resident #1 was standing in the doorway of the administrator's office speaking to direct care staff A, the home's administrator. Resident #1 was standing with [redacted] right hand on [redacted] walker and [redacted] left hand on the door frame, when direct care staff A abruptly ended the conversation and slammed the door, pinching the resident's left 4th finger between the door and frame and causing the resident to fall backwards and hit [redacted] head. Direct care staff A opened the door and asked "What happened?" and the resident replied "You slammed the door on my finger!" Resident #1 was very upset and in a great deal of pain. The home's nursing staff administered first aid and called for an ambulance which transported the resident to the hospital for treatment where [redacted]e was diagnosed with an open fracture of tuft of distal phalanx and a laceration requiring ten sutures.

The incident report sent to the Department, received on [redacted]/25, did not indicate that the injury was caused by a staff person.

Repeat Violation: 1/9/25 et al., 11/22/24

Plan of Correction ***Accept [redacted] - 06/26/2025)***

The Executive Director (ED) submitted a corrected incident report to the Department on June 4, 2025, clearly identifying that the injury sustained by Resident #1 was caused by the actions of a staff member. The updated report was submitted in accordance with the Department's designated reporting format and timeline.

To prevent recurrence, the ED or designee will re-educate all department heads and nursing leaders by June 25, 2025, on proper incident reporting procedures, including the requirement to accurately document all known or suspected causes of injury—particularly when staff involvement is suspected. The training will also reinforce the 24-hour reporting requirement and the obligation to include all relevant details in the initial report to the Department. Training records will be maintained per § 2800.65(l).

To support compliance, the ED or designee will conduct weekly audits of all incident reports for four consecutive weeks, beginning June 17, 2025, to verify that each report is submitted within 24 hours and includes all required details. A log of audits will be maintained and reviewed during Quality Assurance and Improvement Program (QAIP) meetings with the next meeting scheduled no later than July 9, 2025. Documentation of Quality Assurance meetings will be maintained.

Licensee's Proposed Overall Completion Date: *07/09/2025*

Evidence of Completion ***Not Implemented [redacted] - 10/15/2025)***

See attached.

23a ADL assistance

3. Requirements

2800.
23.a. A residence shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #2's Service Plan Report, dated [redacted]/25, indicates "Resident receives one (1) I'm Okay check on night shift – Date initiated 4/2/25". However, on the overnight shift from 10:00 p.m. on 5/15/25 to 6:00 a.m. on 5/16/15, staff did not check on the resident.

23a ADL assistance (continued)

On [redacted]/25 at 1:33 a.m., resident #2 fell in front of [redacted] recliner in the resident's bedroom and could not get up. The resident laid on the floor until 5:37 a.m., when the resident's [redacted] notified the residence that [redacted] was on the floor and in distress and staff came to assist [redacted]. Upon arrival, staff found the resident in discomfort and [redacted] adult brief was soaked in urine.

Repeat Violation: 1/9/25 et al., 11/22/24

Plan of Correction ***Accept [redacted] - 06/26/2025)***

The Executive Director (ED) reviewed the incident involving Resident #2 and confirmed that staff failed to perform the required overnight "I'm Okay" check on the night of [redacted] 2025. Staff involved were immediately s[redacted] pending investigation by AAA and BHSL. The service plan for Resident #2 was also reviewed and revalidated with the interdisciplinary team to support accuracy and clarity.

To mitigate recurrence, all direct care staff will be re-educated by July 9th, 2025, on the importance of following each resident's support plan, with a focus on overnight safety checks and documentation. Education records will be maintained in compliance with § 2800.65(l).

To ensure ongoing compliance, the ED or designee will conduct random weekly audits of overnight care documentation for four consecutive weeks or until compliance has been achieved, beginning the week of June 10, 2025. These audits will verify that all required checks are performed and documented per residents' support plans. Audit results will be reviewed in the next Quality Assurance and Improvement Program (QAIP) meeting and corrective action will be taken if discrepancies are identified. The next Quality Assurance meeting is scheduled for no later than July 9, 2025. Documentation of Quality Assurance meetings will be maintained.

Licensee's Proposed Overall Completion Date: *07/09/2025*

Evidence of Completion ***Not Implemented [redacted] - 10/15/2025)***

See attached.

4. Requirements

2800.

23.a. A residence shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #3's assessment and support plan, dated [redacted]/24, indicates the resident is a two person transfer with a Hoyer lift and requires assistance with toileting. However, according to resident interviews, resident #3 indicates [redacted] has waited very long periods of time to receive assistance from staff and indicates there have been many times [redacted] was transferred by only one staff person using the Hoyer lift.

The resident's Call Bell Report indicates the following:

On 5/28/25 at 5:27pm resident #3 pushed [redacted] call bell and waited 32 minutes for staff to answer and provide care.

On 5/30/25 at 12:06pm resident #3 pushed [redacted]r call bell and waited 36 minutes for staff to answer and provide care.

On 5/31/25 at 9:41pm resident #3 pushed [redacted] call bell and waited 31 minutes for staff to answer and provide care.

On 6/2/25 at 2:49pm resident #3 pushed [redacted] call bell and waited 34 minutes for staff to answer and provide care.

Repeat Violation: 1/9/25 et al, 11/22/24

23a ADL assistance *(continued)*

Plan of Correction ***Accept [redacted] - 06/26/2025)***

The Executive Director (ED) and Health and Wellness Director (HWD) immediately reviewed Resident #3's assessment and support plan and confirmed the requirement for a two-person assist with a Hoyer lift and toileting.
To mitigate recurrence, all direct care staff will be re-trained by July 9, 2025, on the importance of adhering to each resident's support plan, with special emphasis on mechanical lift safety. Education will also include expectations for timely response to call lights. Staff training will be conducted by the HWD and documented in accordance with regulation § 2800.65(l). Any staff found providing one-person Hoyer transfers receives mandatory re-education and documented corrective action.
To monitor compliance, the ED or designee will conduct daily audits of call bell response times using electronic records, reviewing any response exceeding 15 minutes for four consecutive weeks or until compliance has been achieved.
These audit results will be reviewed during weekly leadership huddles and discussed at the next Quality Assurance meeting, scheduled no later than July 9, 2025. Immediate corrective action will be taken for any deviations identified. Documentation of audits and Quality Assurance meetings will be maintained.

Licensee's Proposed Overall Completion Date: *07/09/2025*

Evidence of Completion ***Not Implemented [redacted] 10/15/2025)***

See attached.

5. Requirements

2800.
23.a. A residence shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #4's assessment and support plan, dated [redacted]/24, indicates the resident is a two person transfer with a Hoyer lift and requires assistance with toileting. However, according to resident interviews, resident #4 indicates [redacted] has waited very long periods of time to receive assistance from staff.
The resident's Call Bell Report indicates the following:
On 5/25/25 at 8:42am resident #4 pushed [redacted] call bell and waited 36 minutes for staff to answer and provide care.
On 5/25/25 at 3:01pm resident #4 pushed [redacted] call bell and waited 34 minutes for staff to answer and provide care.
On 5/28/25 at 2:05pm resident #4 pushed [redacted] call bell and waited 1 hour 8 minutes for staff to answer and provide care.
On 5/29/25 at 6:16pm resident #4 pushed [redacted] call bell and waited 48 minutes for staff to answer and provide care.
On 5/29/25 at 8:12pm resident #4 pushed [redacted] call bell and waited 35 minutes for staff to answer and provide care.
On 5/30/25 at 1:58pm resident #4 pushed [redacted] call bell and waited 30 minutes for staff to answer and provide care.
On 6/1/25 at 5:55pm resident #4 pushed h[redacted]all bell and waited 40 minutes for staff to answer and provide care.
.
Repeat Violation: 1/9/25 et al, 11/22/24

Plan of Correction ***Accept [redacted] - 06/26/2025)***

The Executive Director (ED) and Health and Wellness Director (HWD) immediately reviewed Resident #4's assessment and support plan and confirmed the requirement for a two-person assist with a Hoyer lift and toileting.
To mitigate recurrence, all direct care staff will be re-trained by July 9, 2025, on the importance of adhering to each resident's support plan, with special emphasis on mechanical lift safety. Education will also include expectations for

23a ADL assistance (continued)

timely response to call lights. Staff training will be conducted by the HWD and documented in accordance with regulation § 2800.65(l). Any staff found providing one-person Hoyer transfers receives mandatory re-education and documented corrective action.

To monitor compliance, the ED or designee will conduct daily audits of call bell response times using electronic records, reviewing any response exceeding 15 minutes for four consecutive weeks or until compliance has been achieved.

These audit results will be reviewed during weekly leadership huddles and discussed at the next Quality Assurance meeting, scheduled no later than July 9, 2025. Immediate corrective action will be taken for any deviations identified. Documentation of audits and Quality Assurance meetings will be maintained.

Licensee's Proposed Overall Completion Date: *07/09/2025*

Evidence of Completion ***Not Implemented [redacted] 10/15/2025)***

See attached.

42b Abuse/Neglect

6. Requirements

2800.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

According to multiple staff interviews, on [redacted]/25 at approximately 8:30 a.m., resident #1 was standing in the doorway of the administrator's office speaking to direct care staff A, the home's administrator. Resident #1 was standing with [redacted] right hand on [redacted] walker and [redacted] left hand on the door frame, when direct care staff A abruptly ended the conversation and slammed the door, pinching the resident's left 4th finger between the door and frame and causing the resident to fall backwards and hit [redacted] head. Direct care staff A opened the door and asked "What happened?" and the resident replied "You slammed the door on my finger!" Resident #1 was very upset and in a great deal of pain. The home's nursing staff administered first aid and called for an ambulance which transported the resident to the hospital for treatment where [redacted] was diagnosed with an open fracture of tuft of distal phalanx and a laceration requiring ten sutures.

Repeat Violation: 1/9/25 et al, 11/22/24

Plan of Correction ***Accept [redacted] - 06/26/2025)***

The Executive Director (ED) or designee immediately reviewed the incident involving Resident #1 that occurred on May 23, 2025. Staff person A, who slammed the door causing the resident's injury, was s[redacted] immediately and has since been [redacted]. Internal reporting was completed and first aid was provided. Emergency services were contacted, and the resident was treated at the hospital and returned to the community the same day.

To support compliance, beginning June 17, 2025, the ED or designee will conduct weekly interviews with five randomly selected residents or their legal representative for four weeks, asking about their experience with care and staff interactions. Responses will be documented and reviewed for concerns. Additionally, all reported grievances or incidents involving potential mistreatment will be immediately reviewed by the ED for appropriate action and reporting.

Findings will be discussed during the next Quality Assurance meeting scheduled no later than July 9, 2025. Any patterns or violations will result in immediate corrective action and additional staff intervention. Documentation of Quality Assurance meetings and audits will be maintained.

42b Abuse/Neglect *(continued)*

Licensee's Proposed Overall Completion Date: *07/09/2025*

Evidence of Completion ***Not Implemented [redacted]/15/2025)***

See attached.

7. Requirements

2800.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident #2's Service Plan Report, dated [redacted]/25, indicates "Resident receives one (1) I'm Okay check on night shift – Date initiated 4/2/25". However, on the overnight shift from 10:00 p.m. on 5/15/25 to 6:00 a.m. on 5/16/15, staff did not check on the resident.

On [redacted]/25 at 1:33 a.m., resident #2 fell in front of [redacted]r recliner in the resident's bedroom and could not get up. The resident laid on the floor until 5:37 a.m., when the resident's [redacted] notified the residence that [redacted] was on the floor and in distress and staff came to assist [redacted] Upon arrival, staff found the resident in discomfort and [redacted] adult brief was soaked in urine.

Repeat Violation: 1/9/25 et al, 11/22/24

Plan of Correction ***Accept ([redacted] - 06/26/2025)***

The Executive Director (ED) and Health and Wellness Director (HWD) reviewed the incident involving Resident #2, which occurred on [redacted] 16, 2025. It was confirmed that the overnight staff failed to complete the resident's required "I'm Okay" safety check, as documented in their service plan. Staff responsible were [redacted] immediately and [redacted] subsequently. Resident #2's care plan was re-reviewed with all relevant team members to ensure awareness and compliance.

To mitigate recurrence, all direct care staff will be re-educated by July 9, 2025, on the importance of adhering to scheduled safety checks and the expectations outlined in residents' service plans. Training will be completed by ED or designee and will emphasize resident rights, neglect prevention, and documentation practices. Training records will be maintained in accordance with § 2800.65(l).

To ensure ongoing compliance, the ED or designee will conduct random weekly audits of overnight care documentation for four consecutive weeks or until compliance has been achieved, beginning the week of June 10, 2025. These audits will verify that all required checks are performed and documented per residents' support plans. Audit results will be reviewed in the next Quality Assurance and Improvement Program (QAIP) meeting and corrective action will be taken if discrepancies are identified. The next Quality Assurance meeting is scheduled for no later than July 9, 2025. Documentation of Quality Assurance meetings will be maintained.

Licensee's Proposed Overall Completion Date: *07/09/2025*

Evidence of Completion ***Not Implemented [redacted] - 10/15/2025)***

See attached.

44d Complaints - investigation

8. Requirements

2800.
44.d. The residence shall ensure investigation and resolution of complaints. The home shall designate the staff person responsible for receiving complaints and determining the outcome of the complaint.

44d Complaints - investigation *(continued)*

Description of Violation

On numerous occasions resident #2's [redacted] has made oral complaints to the residence related to the resident's care to include the request that a specific staff person not be allowed in the resident's bedroom to provide care. However, there is no log kept of the family's complaints or any information on outcomes.

Repeat Violation: 1/9/25 et al

Plan of Correction ***Accept [redacted] - 06/26/2025)***

The Executive Director (ED) and Health and Wellness Director (HWD) reviewed concerns raised by Resident #2's [redacted] and confirmed that no formal documentation had been maintained regarding oral complaints, nor was there clear follow-up or resolution tracking. The specific staff member has been [redacted] since then.
To mitigate recurrence, the ED will re-educate all department leaders by July 9, 2025, on the requirement to log all complaints—verbal or written. Staff will be trained on complaint resolution protocols, including designated personnel responsibilities, timeliness of follow-up, and documentation of outcomes. The ED or designee will serve as the designated point of contact for complaint intake and resolution, and documentation will be maintained in accordance with § 2800.65(l).
To support compliance, beginning June 17, 2025, the ED or designee will audit the complaint log weekly for four consecutive weeks to verify documentation of concerns and follow-up actions taken. All active complaints will be reviewed during the next Quality Assurance meeting no later than July 9, 2025, and corrective action will be initiated immediately if process failures are found.

Licensee's Proposed Overall Completion Date: *07/09/2025*

Evidence of Completion ***Implemented [redacted] - 10/15/2025)***

See attached.

51 Criminal background checks

9. Requirements

2800.
51.a. Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).
51.b. The hiring policies shall be in accordance with the Department of Aging's Older Adult Protective Services Act policy as posted on the Department of Aging's web site.

Description of Violation

Direct care staff B, hired [redacted]/25, did not have a criminal background check conducted until 3/3/25.

Repeat Violation: 11/22/24

Plan of Correction ***Accept [redacted] - 06/26/2025)***

The Executive Director (ED) and Human Resources designee reviewed the personnel file of direct care staff B and confirmed that a criminal background check was not completed prior to their hire date of [redacted] 2025. The background check was not conducted until March 3, 2025. Staff B was removed from the schedule due to another situation. No findings were noted on the delayed background check. The error was reviewed with the HR team and the ED.
To mitigate recurrence, the ED and or designee will educate all hiring managers by July 9, 2025, on the regulatory requirement that criminal background checks. Training records will be maintained in accordance with § 2800.65(l).
To support compliance, beginning June 17, 2025, the ED or designee will audit all new hire files weekly for four

51 Criminal background checks (continued)

consecutive weeks to verify the presence of completed background checks. Files missing documentation will result in immediate corrective action. Audit results will be reviewed at the next Quality Assurance meeting, scheduled no later than July 9, 2025.

Licensee's Proposed Overall Completion Date: *07/09/2025*

Evidence of Completion ***Not Implemented [redacted] - 10/15/2025)***

See attached.

60a Staffing/support plan needs

10. Requirements

2800.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan. Residence staff or service providers who provide services to the residents in the residence shall meet the applicable professional licensure requirements.

Description of Violation

On 5/25/25 there were 40 residents in the residence, 12 of which were immobile and 5 requiring 2 person assistance with transfers using a Hoyer Lift. However, during the overnight shift from 11:30 p.m. on 5/25/25 to 6:00 a.m. on 5/26/25, there were only 2 direct care staff working in the residence.

On 6/1/25 there were 40 residents in the residence, 12 of which were immobile and 5 requiring 2 person assistance with transfers using a Hoyer Lift. However, during the overnight shift from 11:30 p.m. on 6/1/25 to 6:00 a.m. on 6/2/25, there were only 2 direct care staff working in the residence.

According to multiple resident and staff interviews, the residence routinely does not have a staff person trained to administer medications during overnight shifts. On 5/25/25 and 6/1/25, during the overnight shift from 11:30 p.m. to 6:00 a.m., there were only 2 direct care staff working in the residence and neither were trained to administer medications.

Repeat Violation: 1/9/25 et al

Plan of Correction ***Accept [redacted] - 06/26/2025)***

The Executive Director (ED) or designee, reviewed staffing patterns for the overnight shifts on May 25 and June 1, 2025. It was confirmed that only two direct care staff were scheduled during the overnight shifts for those dates, despite 12 residents being immobile and 5 requiring two-person Hoyer transfers. No trained med passer was scheduled to administer medications on the overnight shift on 6/1/25. This staffing level was insufficient to meet resident care needs as outlined in their support plans. Immediate supplemental staffing was added with agency staff until a long-term solution could be implemented.
To mitigate recurrence, the ED will reconfigure the overnight staffing schedule by July 9, 2025, to ensure that at least one trained medication staff and enough personnel to meet two-person transfer needs are scheduled for overnight shift. Staffing assignments will be cross-checked against resident acuity levels and Hoyer transfer requirements. Documentation of training and staffing rosters will be maintained in accordance with § 2800.65(l).
To ensure compliance, beginning June 17, 2025, the ED or designee will conduct weekly staffing audits for four consecutive weeks to confirm that shift assignments meet resident service plan needs, including sufficient coverage for two-person transfers and medication administration. Any gaps identified will trigger immediate staffing

60a Staffing/support plan needs (continued)

adjustments . Results will be reviewed at the next Quality Assurance meeting scheduled no later than July 9, 2025.

Licensee's Proposed Overall Completion Date: *07/09/2025*

Evidence of Completion ***Implemented [redacted] - 10/15/2025)***

See attached.

65a Fire Safety-1st day

11. Requirements

2800.

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.
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

Direct care staff B, hired [redacted]/25, did not receive training on or prior to [redacted] first day of work in the following: evacuation procedures, Staff duties and responsibilities during fire drills, as well as during 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, the location and use of fire extinguishers, smoke detectors and fire alarms and telephone use and notification of emergency services.

Direct care staff C, hired [redacted]25, did not receive training on or prior to [redacted] first day of work in the following: evacuation procedures, Staff duties and responsibilities during fire drills, as well as during 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, the location and use of fire extinguishers, smoke detectors and fire alarms and telephone use and notification of emergency services.

Repeat Violation: 1/9/25 et al

Plan of Correction ***Accept [redacted] - 06/26/2025)***

The Executive Director (ED) or designee reviewed the training records for direct care staff B and C and confirmed that required fire safety training was not completed on or prior to their first day of employment. This includes training on evacuation procedures, designated meeting areas, fire drills, extinguisher locations, and emergency communications. Both employees have since been terminated.

To mitigate recurrence, the ED will re-educate all department leaders and onboarding personnel by July 9, 2025, on the requirement to provide and document fire safety training before any new hire begins work. Training documentation will be maintained in accordance with § 2800.65(l).

To support compliance, beginning June 17, 2025, the ED or designee will conduct weekly audits of all new hire

65a Fire Safety-1st day (continued)

records for four weeks, confirming that fire safety training was completed on or before the employee's start date. Audit findings will be reviewed during the next Quality Assurance meeting scheduled no later than July 9, 2025. Immediate corrective action will be taken for any discrepancy.

Licensee's Proposed Overall Completion Date: *07/09/2025*

Evidence of Completion ***Implemented [redacted] - 10/15/2025)***

See attached.

65e Rights/Abuse 40 Hours

12. Requirements

2800.

65.e. 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.
5. Safe management techniques.
6. Core competency training that includes the following:
   i. Person-centered care.
   ii. Communication, problem solving and relationship skills.
   iii. Nutritional support according to resident preference.

Description of Violation

Direct care staff B, hired [redacted]/25, did not receive training on or prior to completion of [redacted] first first 40 hours of work in the following: Resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act, reporting of reportable incidents and conditions.

Direct care staff C, hired [redacted]/25, did not receive training on or prior to completion of [redacted] first first 40 hours of work in the following: Resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act, reporting of reportable incidents and conditions.

Repeat Violation: 1/9/25 et al

Plan of Correction ***Accept [redacted] - 06/26/2025)***

The Executive Director (ED) or designee reviewed the training records for direct care staff B and C and confirmed that both employees did not receive the required training on resident rights, the emergency medical plan, and mandatory reporting of abuse and neglect within the first 40 hours of employment. Both staff members have since been [redacted].

To mitigate recurrence, the ED and or designee will update the new hire training checklist to ensure that all required 40-hour training components are scheduled and completed within the specified timeframe. A new internal tracking tool will be implemented by July 9, 2025, to monitor progress toward 40-hour compliance. The ED or designee will verify completion before direct care staff are allowed to work beyond 40 hours. Training documentation will be maintained in accordance with § 2800.65(l).

To support compliance, beginning June 17, 2025, the ED or designee will audit all new hire training records weekly for four consecutive weeks, verifying that each staff member completed the mandated topics within 40 hours of

65e Rights/Abuse 40 Hours (continued)

hire. Findings will be reviewed during the next Quality Assurance meeting no later than July 9, 2025, and corrective action will be initiated for any lapse.

Licensee's Proposed Overall Completion Date: *07/09/2025*

Evidence of Completion ***Implemented [redacted] - 10/15/2025)***

See attached.

65g Initial direct care training

13. Requirements

2800.

65.g. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   - i. Safe management techniques.
   - ii. ADLs and IADLs
   - iii. Personal hygiene.
   - iv. Care of residents with mental illness, neurological impairments, an intellectual disability and other mental disabilities.
   - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   - vi. Implementation of the initial assessment, annual assessment and support plan.
   - vii. Nutrition, food handling and sanitation.
   - viii. Recreation, socialization, community resources, social services and activities in the community.
   - ix. Gerontology.
   - x. Staff person supervision, if applicable.
   - xi. Care and needs of residents with special emphasis on the residents being served in the residence.
   - xii. Safety management and hazard prevention.
   - xiii. Universal precautions.
   - xiv. The requirements of this chapter.
   - xv. The signs and symptoms of infections and infection control.
   - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the residence.
   - xvii. Behavioral management techniques.
   - xviii. Understanding of the resident's assessment and how to implement the resident's support plan.
   - xix. Person-centered care and aging in place.

Description of Violation

Direct care staff B, hired [redacted]/25, did not complete 18 hours of training as required by 2800.65g (1-3). prior to administering direct care services to residents.

Direct care staff C, hired [redacted]25, did not complete 18 hours of training as required by 2800.65g (1-3). prior to administering direct care services to residents.

Repeat Violation: 1/9/25 et al

65g Initial direct care training *(continued)*

Plan of Correction ***Accept [redacted] - 06/26/2025)***

The Executive Director (ED) or designee reviewed the training records of direct care staff B and C and confirmed that neither staff member completed the required 18 hours of direct care staff training outlined in § 2800.65(q)(1–3) before delivering care to residents. Both staff were removed from the schedule and have since been [redacted].
To mitigate recurrence, the ED or designee will review the orientation checklist to verify that the full 18-hour training curriculum is scheduled, tracked, and completed prior to assigning any new staff to unsupervised care. A training verification form will be signed by both the employee and supervisor prior to shift assignment. These forms will be maintained in accordance with § 2800.65(l).
To support compliance, beginning June 17, 2025, the ED or designee will audit all new hire training records weekly for four consecutive weeks, verifying completion of all required hours and training topics prior to assignment. Any discrepancies will result in immediate removal from the schedule until compliance is verified.
Audit results will be reviewed during the next Quality Assurance meeting no later than July 9, 2025, and ongoing compliance will be incorporated into routine QA reviews.

Licensee's Proposed Overall Completion Date: *07/09/2025*

Evidence of Completion ***Not Implemented [redacted] - 10/15/2025)***

See attached.

132g Fire drills – days/times

14. Requirements

2800.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

According to multiple staff interviews, since at least January 2025, the residence routinely staffed the overnight shift with two direct care staff. However, the home's fire drill record indicates the sleeping hours fire drill conducted on 2/13/25 at 6:15 a.m. included four direct care staff participating.

Plan of Correction ***Accept [redacted] - 06/26/2025)***

The Executive Director (ED) and Environmental Services Manager reviewed the fire drill schedule and records and confirmed that the fire drill conducted on February 13, 2025, during sleeping hours included four staff, despite normal overnight staffing being limited to two staff members. This did not reflect realistic emergency conditions and was not compliant with § 2800.132(g).
To mitigate recurrence, the ED and Environmental Services Manager will verify fire drill schedule by July 1, 2025, to ensure drills are held during routine staffing levels. A drill schedule will be maintained and drills will be unannounced for participating staff to simulate actual conditions.
To ensure compliance, beginning June 17, 2025, the ED will review fire drill logs monthly for three consecutive months to confirm drills are held in accordance with regulation. Reviews will confirm varying times, days, and typical staffing levels. Any variances will require documentation and justification.
Fire drill records and audit findings will be reviewed during the next Quality Assurance meeting, no later than July 9, 2025, and maintained for review per regulatory standards.

Licensee's Proposed Overall Completion Date: *07/09/2025*

Evidence of Completion ***Implemented [redacted] - 10/15/2025)***

See attached.

183b Medications and syringes locked

15. Requirements

2800.
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 living unit.

Description of Violation

There was a 150g tube of Voltaren (Diclofenac sodium topical gel 1%) Arthritis pain reliever, unsecured, unattended and accessible, on the table next to the recliner in bedroom [redacted].

Plan of Correction ***Accept [redacted] - 06/26/2025)***

The Executive Director (ED) or designee investigated the unsecured Voltaren gel found in Resident [redacted] unit and confirmed it was left unattended on a table within reach. The medication was removed and secured in the locked medication storage area on the same day the violation was identified. The resident and family were re-educated on the importance of storing medications securely and the risks of leaving medications accessible in the living area.
To mitigate recurrence, the HWD or designee will re-educate medication trained staff by July 9, 2025, on the requirements of § 2800.183(b), which mandates that all prescription medications, OTC medications, CAM, and syringes must be locked at all times, including within a resident's apartment. Staff will be instructed to immediately report and remove any unsecured medication found. Documentation of training will be maintained in accordance with § 2800.65(l).
To support compliance, beginning June 17, 2025, the HWD or designee will conduct weekly random visual inspections of five resident living units for four weeks, specifically for residents who are not assessed as capable of safely self-administering medications. All findings will be documented, and any unsecured items will be removed and addressed with staff and residents. Audit results will be reviewed during the next Quality Assurance meeting scheduled no later than July 9, 2025.

Licensee's Proposed Overall Completion Date: *07/09/2025*

Evidence of Completion ***Implemented [redacted] - 10/15/2025)***

See attached.

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

Facility Information

Name: *WESTLAKE WOODS AL* **License #:** *45407* **License Expiration:** *10/31/2025*

Address: *3302 WEST LAKE ROAD, ERIE, PA 16505*

County: *ERIE* **Region:** *WESTERN*

Administrator

[redacted]

Legal Entity

Name: *ERIE OPS LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *10/31/1997* **Issued By:** *Dept L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *77* **Waking Staff:** *58*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional* **Exit Conference Date:** *08/12/2025*

Inspection Dates and Department Representative

07/29/2025 - On-Site: [redacted]
07/30/2025 - On-Site:
08/07/2025 - On-Site:
09/12/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *79* **Residents Served:** *45*

Special Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *45*

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

Have Mobility Need: *32* **Have Physical Disability:** *1*

Inspections / Reviews

07/29/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/26/2025*

09/29/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/26/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/07/2025*

10/09/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/08/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/30/2025*

11/18/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *10/30/2025*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

15a Resident abuse report

1. Requirements

2800.
15.a. The residence shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 7/24/25 or 7/25/25, staff person A was informed by a visitor that they observed a video of staff person B providing care to resident #1. This visitor stated they were scared and concerned about their loved one's care after observing staff person B's behavior while providing care to the other resident and no longer wanted staff person B to provide care to their loved one. The residence did not report to the local Area Agency on Aging until requested to do so on until 7/30/25.

Around 7/23/25, interviews indicated staff reported knowledge of staff person B reportedly spilled some coffee on the resident after staff person B slammed down a cup of coffee in front of resident #2 to intimidate the resident. Additionally, it was reported resident #2 has been antagonized and intimidated on more than one occasion by staff person B. The residence was not made aware this allegation included staff person C as well until 7/30/25. The residence did not report to the local Area Agency on Aging until requested to do so on until 7/30/25.

REPEAT VIOLATION: 1/9/25 et al

Plan of Correction ***Accept [redacted] 10/08/2025)***

All current employees will be re-educated on Resident Rights and the mandatory reporting requirements outlined in regulation 15.a by September 30, 2025. The Executive Director or designee will ensure that all current employees sign documentation verifying completion of this training.
Effective October 1, 2025, all new hires will receive education on Resident Rights, including mandatory reporting under the Older Adult Protective Services Act, during orientation. This training will be documented in the employee file as part of the standard onboarding process.
Beginning October 6, 2025, the Executive Director or designee will audit 10% of employee files weekly for four consecutive weeks to verify that training on Resident Rights and abuse reporting has been completed upon hire. If 100% compliance is not achieved after four weeks, audits will continue until compliance is verified. Ongoing random audits will be conducted quarterly thereafter.
Person Responsible for Implementation and Monitoring:
Executive Director or designee.
Estimated completion date: October 13, 2025

Licensee's Proposed Overall Completion Date: *10/13/2025*

Not Implemented [redacted] - 11/18/2025)

15b Resident abuse-superv plan

2. Requirements

2800.

15b Resident abuse-superv plan *(continued)*

15.b. If there is an allegation of abuse of a resident involving a residence's staff person, the residence shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

An allegation of abuse was presented to the residence's management by 7/25/25, against staff person B, regarding resident #1 care received on 7/23/25, at approximately 5:13 p.m.; however, direct care staff person B continued to provide unsupervised direct care until 7/30/25. Additional interviews conducted on 7/30/25 indicated additional staff persons were also aware of the allegations of caregiver neglect.

An allegation of abuse was present to the residence's management around 7/23/25, against staff person B, regarding resident #2 being antagonized, intimidated, and coffee being purposely spilled on resident #2. However, direct care staff person B continued to provide unsupervised direct care until 7/30/25.

Plan of Correction ***Accept [redacted] - 10/08/2025)***

All current employees will be re-educated on Resident Rights and the mandatory reporting requirements outlined in regulation 15.a by September 30, 2025. The Executive Director or designee will ensure that all current employees sign documentation verifying completion of this training.
Effective October 1, 2025, all new hires will receive education on Resident Rights, including mandatory reporting under the Older Adult Protective Services Act, during orientation. This training will be documented in the employee file as part of the standard onboarding process.
Beginning October 6, 2025, the Executive Director or designee will audit 10% of employee files weekly for four consecutive weeks to verify that training on Resident Rights and abuse reporting has been completed upon hire. If 100% compliance is not achieved after four weeks, audits will continue until compliance is verified. Ongoing random audits will be conducted quarterly thereafter.
Person Responsible for Implementation and Monitoring:
Executive Director or designee.
Estimated completion date: October 13, 2025

Licensee's Proposed Overall Completion Date: *10/13/2025*

Not Implemented [redacted] - 11/18/2025)

16c Incident reporting

3. Requirements

2800.
16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

On 7/24/25 or 7/25/25, staff person A was informed by a visitor that they observed a video of staff person B providing care to resident #1. This visitor stated they were scared and concerned about their loved one's care after observing staff person B's behavior while providing care to the other resident and no longer wanted staff person B to provide care to their loved one. The residence did not report to The Department until requested to do so on 7/30/25.

16c Incident reporting (continued)

Around 7/23/25, interviews indicated staff reported knowledge of staff person B reportedly spilled some coffee on the resident after staff person B slammed down a cup of coffee in front of resident #2 to intimidate the resident. Additionally, it was reported resident #2 has been antagonized and intimidated on more than one occasion by staff person B. The residence was not made aware this allegation included staff person C as well until 7/30/25. The residence did not report to The Department until requested to do so on until 7/30/25.

REPEAT VIOLATION: 11/22/24, 1/9/25 et al

Plan of Correction ***Accept [redacted] - 10/08/2025)***

All current employees will be re-educated on Resident Rights and the mandatory reporting requirements outlined in regulation 15.a by September 30, 2025. The Executive Director or designee will ensure that all current employees sign documentation verifying completion of this training.
Effective October 1, 2025, all new hires will receive education on Resident Rights, including mandatory reporting under the Older Adult Protective Services Act, during orientation. This training will be documented in the employee file as part of the standard onboarding process.
Beginning October 6, 2025, the Executive Director or designee will audit 10% of employee files weekly for four consecutive weeks to verify that training on Resident Rights and abuse reporting has been completed upon hire. If 100% compliance is not achieved after four weeks, audits will continue until compliance is verified. Ongoing random audits will be conducted quarterly thereafter.
Person Responsible for Implementation and Monitoring:
Executive Director or designee.
Estimated completion date: October 13, 2025

Licensee's Proposed Overall Completion Date: *10/13/2025*

Not Implemented [redacted] - 11/18/2025)

19 Waiver application

4. Requirements

2800.
19. Waivers
    a. A home may submit a written request for a waiver of a specific requirement contained in this chapter. The waiver request must be on a form prescribed by the Department. The Secretary, or the Secretary's appointee, may grant a waiver of a specific requirement of this chapter if the following conditions are met:
        1. There is no jeopardy to the residents.
        2. There is an alternative for providing an equivalent level of health, safety and well-being protection of the residents.
        3. Residents will benefit from the waiver of the requirement.
    b. Following receipt of a waiver request, the Department will post the waiver request on the Department's website with a 30-day public comment period prior to final review and decision on the requested waiver.
    c. The scope, definitions, applicability or residents' rights, assisted living service delivery requirements, special care designation requirements, staff training requirements, disclosure requirements, complaint rights or procedures, notice requirements to residents or the resident's family, contract requirements, reporting requirements, fire safety requirements, assessment, support plan or service delivery requirements under this chapter may not be waived.

19 Waiver application *(continued)*

d. At least 30 days prior to the submission of the completed written waiver request to the Department, the home shall provide a copy of the completed written waiver request to the affected resident and designated person to provide the opportunity to submit comments to the Department. The residence shall provide the affected resident and designated person with the name, address and telephone number of the Department staff person to submit comments.

e. The residence shall discuss the waiver request with the affected resident and designated person upon the request of the resident or designated person.

f. The residence shall notify the affected resident and designated person of the approval or denial of the waiver. A copy of the waiver request and the Department's written decision shall be posted in a conspicuous and public place within the residence.

g. The Department will review waivers annually to determine compliance with the conditions required by the waiver. The Department may revoke the waiver if the conditions required by the waiver are not met. When the Department revokes a standing waiver from a residence that residence may appeal the revocation consistent with § 2800.12 (relating to appeals).

Description of Violation

On 7/29/25, a copy of the waiver request and the Department's written decision for the residence's approved GLP-1 waiver was not posted in a conspicuous and public place within the residence.

Plan of Correction ***Accept [redacted] - 09/29/2025)***

On 7/29/25, it was identified that a copy of the Department's written decision for the residence's approved GLP-1 waiver was not posted in a conspicuous and public place within the residence. The waiver decision was immediately posted on 7/30/25, ensuring visibility and compliance with regulatory requirements.

To prevent recurrence, the Executive Director re-educated the Health and Wellness Director and Administrative staff on the requirement to post all waiver requests and written decisions in a conspicuous and public location. A tracking log has been implemented to monitor all current and future waivers, including posting date and verification by the Executive Director.

Compliance will be monitored by the Executive Director through monthly environmental rounds, where waiver postings will be checked as part of regulatory compliance audits. Findings will also be reviewed during Quality Assurance meetings to ensure sustained compliance.

All corrective actions will be completed by 10/30/25, with the Executive Director responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Implemented [redacted] - 11/18/2025)

23a ADL assistance

5. Requirements

2800.

23.a. A residence shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #1's assessment and support plan (ASP), dated [redacted]/25, indicated this resident required 2-person belt transfer; however, on [redacted]/25, at approximately 5:13 p.m., this resident was transferred under the right arm by direct care staff person B only and without the use of the assistive device. Additionally, on 6/29/25, the hospital ordered resident #1 to wear sling day and night for right clavicle fracture. Avoid arm positions or motions that cause pain.

Resident #3 did not receive assistance with showers twice a week as indicated on [redacted] support plan, dated [redacted]/25. When interviewed on 8/7/25, the resident stated, "you have to beg for a shower" and [redacted] last shower was over 5 days late. When re-interviewed on 8/12/25, the resident stated [redacted] last shower was on 8/6/25 and she did not receive a shower on 8/10/25 as scheduled. This resident has received one shower a week on average and the shower logs

23a ADL assistance (continued)

indicated multiple showers not signed as given.

Residents #4 did not receive assistance with showers twice a week as indicated on his support plan, dated [redacted]/25. [redacted] last shower was over 5 days late. The resident's last shower was on 8/6/25 and [redacted] did not receive a shower on 8/10/25 as scheduled. This resident has received one shower a week on average and the shower logs indicated multiple showers not signed as given.
Resident #5 support plan, dated [redacted]/25, indicated the resident requires assistance with showers every Tuesday; however, resident interview indicated the last shower has been over 2 weeks. Shower logs indicated multiple showers not signed as given.

Resident #6's support plan, dated 9/26/25, indicated this resident requires assistance with showers on Sunday and Thursday by direct care staff; however, the resident interview indicated this residents family is providing this activity of daily living (ADL) since the residence does not. Shower logs indicated showers were not signed as given.

Resident #7 was identified by the residence as someone with a mobility need, requires assistance with toileting and is a 2 person transfer with Hoyer lift. Call bell report indicates the following:
On 7/19/25 at 6:49 a.m. resident #7 pushed [redacted] call bell and waited 30 minutes, 29 seconds for staff to help [redacted].
On 7/2025 at 8:09 a.m. resident #7 pushed [redacted] call bell and waited 35 minutes, 29 seconds for staff to help [redacted].
On 7/24/25 at 8:36 p.m. resident #7 pushed [redacted] call bell and waited 40 minutes, 18 seconds for staff to help [redacted].
On 7/25/25 at 7:59 p.m. resident #7 pushed [redacted] call bell and waited 30 minutes, 19 seconds for staff to help [redacted].

Resident #8 was identified by the residence as someone with a mobility need, requires assistance with toileting and colostomy needs 3-4 times daily, and is a 1 person assist with transfers. On 7/19/25 at 4:10 p.m. resident #8 pushed [redacted] call bell and waited 32 minutes, 47 seconds for staff to help [redacted].

REPEAT VIOLATION: 11/22/24, 1/9/25 et al

Plan of Correction ***Accept [redacted] - 09/29/2025)***

Residents identified in the citation have had their support plans reviewed by the Health and Wellness Director, and corrective actions were immediately implemented to ensure required assistance with showers, transfers, and toileting are provided in accordance with each plan of care. Staff members were re-educated on 9/30/25 regarding the requirement to follow each resident's assessment and support plan without deviation, including proper use of assistive devices and adherence to shower schedules.
To address concerns with delayed call light response, all direct care staff were re-educated on expectations for timely response to resident needs on 9/30/25. A call light audit process has been implemented in which response times are reviewed daily by the Health and Wellness Director or designee for a 60-day period, then monthly thereafter. Staff members not meeting expectations will receive immediate coaching and corrective action as appropriate.
To prevent recurrence, the Executive Director and Health and Wellness Director have implemented a weekly review of shower logs and ADL documentation to verify that all services are provided as scheduled and documented accurately. These findings will be presented at monthly Quality Assurance meetings to ensure sustained compliance and identify any trends.
All corrective actions will be fully implemented by 10/30/25. The Executive Director and Health and Wellness Director are responsible for ongoing compliance.

23a ADL assistance *(continued)*

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] - 11/18/2025)

42c Dignity/Respect

8. Requirements

2800.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

Resident #1's assessment and support plan (ASP), dated [redacted]/25, indicated this resident required 2-person belt transfer. Additionally, this resident required the use of a sling due to a right clavicle fracture, diagnosed on 6/29/25. However, on 7/23/25 at 5:13 p.m., resident #1 was wheeled into [redacted] unit by direct care staff person B, who then leaned against the resident's furniture while the resident made multiple attempts to get [redacted] out of [redacted] wheelchair. Direct care staff person B then locked the brakes on resident #1's wheelchair and leaned against furniture again while watching resident to struggle to get out of wheelchair. Direct care staff person B then grabbed resident by [redacted] right arm (clavicle injury) and assisted this resident to a seated position half on the recliner and half on the arm of the chair.

REPEAT VIOLATION: 12/12/24 et al, 4/9/25, 1/9/25 et al

Plan of Correction ***Accept [redacted] - 09/29/2025)***

The Executive Director designee s[redacted] Staff person B upon DHS reporting the incident to [redacted]. Staff person B is no longer employed with the company. The Health and Wellness Director immediately reviewed the incident and reinforced with all caregiving staff the requirement to provide care in a manner that upholds each resident's dignity and respect at all times by 10/1/25. Resident #1's support plan was reviewed and updated to ensure clarity regarding required two-person belt transfers and the use of a sling due to clavicle injury.
All direct care staff received re-education on 9/30/25 regarding resident dignity, proper transfer techniques, and adherence to individual support plans. The Executive Director and Health and Wellness Director are monitoring daily care delivery to ensure interventions are followed and residents are treated respectfully.
To prevent recurrence, the Health and Wellness Director will conduct direct care observations weekly for 60 days, then monthly thereafter, to ensure residents are assisted according to their assessed needs and in a dignified manner. Additionally, dignity and respect in resident interactions will be reinforced during quarterly in-services and reviewed in monthly Quality Assurance meetings.
All corrective actions will be completed by 10-30-25, with the Executive Director and Health and Wellness Director responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] - 11/18/2025)

51 Criminal background checks

9. Requirements

2800.
51. Criminal background checks
    a. Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

51 Criminal background checks *(continued)*

b. The hiring policies shall be in accordance with the Department of Aging's Older Adult Protective Services Act policy as posted on the Department of Aging's web site.

Description of Violation

Direct care staff person D, hired [redacted]/25, did not have a criminal background check completed until 3/24/25.

REPEAT VIOLATION: 11/22/24

Plan of Correction ***Accept [redacted] - 09/29/2025)***

Direct care staff person D, hired [redacted]/25, had a background check completed on 3/24/25. While the background check was ultimately completed and verified, the timing did not meet regulatory requirements.
To correct this, the Executive Director and Health and Wellness Director immediately reviewed all staff records to confirm that background checks were completed and documented for every current employee. No other staff were identified as missing this requirement. A corrective action was made at the time of discovery to verify that staff person D's background check was on file.
To prevent recurrence, the Community has implemented a routine audit process to verify that all required background checks are completed before staff begin employment. The Executive Director will review new hire files prior to start date and sign off to confirm that criminal background checks are complete and documented. Additionally, monthly audits of personnel files are being conducted to ensure ongoing compliance.
This expectation was provided in a retraining for all hiring managers on 9/30/25, and corrective action will be taken for any staff member who does not follow pre-hire compliance requirements. Results of the audits will be reviewed during Quality Assurance meetings to ensure sustained compliance.
All corrective actions will be fully implemented by 10/30/25, with the Executive Director responsible for compliance oversight.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] - 11/18/2025)

65g Initial direct care training

10. Requirements

2800.

65.g. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   - i. Safe management techniques.
   - ii. ADLs and IADLs
   - iii. Personal hygiene.
   - iv. Care of residents with mental illness, neurological impairments, an intellectual disability and other mental disabilities.
   - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   - vi. Implementation of the initial assessment, annual assessment and support plan.
   - vii. Nutrition, food handling and sanitation.
   - viii. Recreation, socialization, community resources, social services and activities in the community.
   - ix. Gerontology.

65g Initial direct care training *(continued)*

x. Staff person supervision, if applicable.
xi. Care and needs of residents with special emphasis on the residents being served in the residence.
xii. Safety management and hazard prevention.
xiii. Universal precautions.
xiv. The requirements of this chapter.
xv. The signs and symptoms of infections and infection control.
xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the residence.
xvii. Behavioral management techniques.
xviii. Understanding of the resident's assessment and how to implement the resident's support plan.
xix. Person-centered care and aging in place.

Description of Violation

Direct care staff person E, hired [redacted]/25, has provided unsupervised assisted living services; however, did not complete 18 hours of training in the following areas:
Initial direct care staff person training to include the following:
(iii) Personal hygiene
(vii) Nutrition, food handling and sanitation.
(viii) Recreation, socialization, community resources, social services and activities in the community.
(xi) Care and needs of residents with special emphasis on the residents being served in the residence.

The following staff did not complete the required 18 hours of training in the topic Care and needs of residents with special emphasis on the residents being served in the residence prior to providing unsupervised assisted living services: Staff person D, hired [redacted]25
Staff person B, [redacted]/25
Staff person F, [redacted]/25
Staff person G,[redacted]/25

REPEAT VIOLATION: 1/9/25 et al

Plan of Correction ***Accept ([redacted] - 09/29/2025)***

To correct this, the Community has completed a crosswalk document mapping all training requirements outlined in the regulation to ensure full compliance with the required 18 hours of orientation and competency topics. A new training checklist will be developed and implemented by 9/30/25 that specifically references each required content area and must be completed and signed off by the supervisor prior to the conclusion of orientation. Staff person E has since been re-educated, and their training record has been updated to reflect the completion of all outstanding requirements.
To prevent recurrence, the Executive Director will verify completion of the training checklist for each new hire before the staff member is permitted to work independently. The Executive Director will conduct monthly audits of personnel files for 60 days, then quarterly thereafter, to confirm compliance with all training requirements. These

65g Initial direct care training (continued)

findings will be reviewed during Quality Assurance meetings to ensure sustainability.
All corrective actions will be fully implemented by 10/30/25, with the Executive Director responsible for compliance oversight.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] - 11/18/2025)

81b Resident equip – good repair

11. Requirements

2800.
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 7/29/25, the bed enabler on resident #8's bed had an opening between the bed and the enabler bar that measured approximately 4 inches; posing an entrapment hazard.

On 7/29/25, the bed enabler on resident #7's bed had an opening between the bed and the enabler bar that measured approximately 3 inches; posing an entrapment hazard.

REPEAT VIOLATION: 6/27/24 et al

Plan of Correction ***Accept[redacted] 09/29/2025)***

On 7/29/25, resident #8's bed enabler was identified as having an approximate 4-inch opening between the bed and the bar, and resident #7's bed enabler was identified as having an approximate 3-inch opening, both of which posed entrapment hazards.
Corrective action was taken immediately. The bed enablers for residents #7 and #8 were removed from use on 7/29/25 and replaced with equipment in good repair that met safety standards. Both residents' assessments and support plans were reviewed and updated to reflect the replacement equipment.
To prevent recurrence, the Health and Wellness Director implemented a process for quarterly audits of all resident equipment to ensure that items remain free of hazards, properly fitted, and in good repair. Direct care staff were re-educated on 9/30/25 regarding the requirement to promptly report any damaged or potentially unsafe equipment so that corrective action can be taken immediately.
Ongoing monitoring will occur through monthly Quality Assurance meetings, where equipment audit findings will be reviewed to identify trends and ensure compliance is sustained.
All corrective actions will be fully implemented by 10/30/25, with the Executive Director and Health and Wellness Director responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] - 11/18/2025)

85a Sanitary conditions

12. Requirements

2800.
85.a. Sanitary conditions shall be maintained.

85a Sanitary conditions *(continued)*

Description of Violation

On 7/30/25, the glucometer labeled for resident #10 was used to measure blood glucose level of 251 for resident #8 on 7/24/25 at 11:25 a.m.

Plan of Correction ***Accept [redacted] - 09/29/2025)***

New glucometers were ordered for all residents requiring individual devices on 7/31/25, and each glucometer has been clearly labeled with the appropriate resident's information to ensure proper use. Team members were re-educated on 8/21 and 10/16/25 regarding infection control standards and the requirement that glucometers are not to be shared or reused between residents under any circumstances.
To prevent recurrence, the Health and Wellness Director or designee will conduct monthly audits of resident equipment, including glucometers, to ensure proper labeling and assignment. Compliance will also be monitored during direct care observations to verify correct practice. These findings will be reviewed during Quality Assurance meetings to ensure sustained compliance.
All corrective actions will be completed by 10/30/25, with the Executive Director and Health and Wellness Director responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] - 11/18/2025)

89b Hot water temperature

13. Requirements

2800.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 7/29/25, at approximately 12:38 p.m., the water temperature at the sink in the bathroom in unit #202 measured 126.1 Fahrenheit.

Plan of Correction ***Accept ([redacted] - 09/29/2025)***

Maintenance adjusted the water temperature regulator for unit #202 to bring the temperature within the safe range, and follow-up testing confirmed that water temperatures were reduced to below 120°F. No residents experienced injury as a result of this event.
To prevent recurrence, the Maintenance Director implemented a monitoring process in which water temperatures will be checked weekly in 10% of resident units and common areas for 4 weeks or until compliance is maintained. Results will be documented and reviewed by the Executive Director. Any variances outside of compliance will be corrected immediately, and corrective actions documented.
Findings from water temperature checks will be reviewed during monthly Quality Assurance meetings to ensure ongoing compliance.
All corrective actions will be completed by 10/30/25, with the Executive Director and Maintenance Director responsible for sustained compliance.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Implemented ([redacted] - 11/18/2025)

100a Exterior – free of hazards

15. Requirements

2800.

100a Exterior – free of hazards *(continued)*

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 7/29/25, the top railing outside emergency exit door #3, was detached from the railing post and posed a fall risk. Additionally, multiple balusters on the first and third section were detached from the top rail and were not securely in place.

Plan of Correction ***Accept ([redacted] - 09/29/2025)***

The railing and balusters were repaired on 9/26/25, and the area was secured until repairs were completed to ensure resident and staff safety. No injuries occurred as a result of this hazard.
To prevent recurrence, the Maintenance Director will audit exterior railings, exits, and other outdoor safety features monthly x4 months until compliance is maintained. Any identified hazards will be corrected immediately, and documentation will be reviewed by the Executive Director. Findings will also be presented at monthly Quality Assurance meetings to monitor compliance and identify trends.
All corrective actions were fully implemented by 10/30/25, with the Executive Director and Maintenance Director responsible for sustained compliance.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] - 11/18/2025)

101j7 Lighting/operable lamp

16. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 7/29/25, there was no source of lighting that could be turned on/off from resident #10's bed as the lamp was not plugged into the wall.

Plan of Correction ***Accept[redacted] - 10/08/2025)***

The Community respectfully contests the violation cited under 2800.101j7. The citation indicates that Resident #10's bed did not have a source of lighting that could be turned on/off from bedside because the lamp was not plugged into the wall. At the time of the survey, the resident's bedside lamp had been unplugged due to needed repair. The resident did in fact have a bedside lamp available, but it was temporarily out of service for safety reasons.
While the Community maintains that a light source was present in the unit, a new preventive measure has been implemented to strengthen compliance. All residents will now be provided with a flashlight at move-in to be kept at the bedside, ensuring that an operable light source is always available, even in the event of equipment repair or maintenance.
The Community therefore maintains that it was in compliance with 2800.101j7 at the time of survey, as a bedside lamp was present, but has nonetheless added an additional safeguard through the flashlight system to ensure redundancy.
During the survey, when it was discovered that the resident's lamp was broken, the lamp was immediately removed from use and verified that resident safety was not at risk. The resident's legal representative was promptly notified and replaced the lamp with an alternative light source. To prevent recurrence, Environmental Services and Housekeeping staff will be re-educated by September 30, 2025, on the requirement to promptly report any furniture or equipment that is not in working order or good repair. Beginning October 6, 2025, the Executive Director or designee will audit 10% of resident apartments weekly for four consecutive weeks, or until full compliance is

101j7 Lighting/operable lamp (continued)

achieved. Ongoing monitoring will occur as part of routine environmental rounds to ensure continued adherence to safety and maintenance standards. All corrective actions will be completed by October 30, 2025, with the Executive Director responsible for implementation and ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Implemented ([redacted] - 11/18/2025)

103e Leftovers

17. Requirements

2800.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 7/29/25, at approximately 11:00 a.m., 5 pieces of cake, a bowl of egg salad, and a bowl with 2 cut lemons were not labeled nor dated.

On 7/29/25, at approximately 11:00 a.m., a bag of oriental vegetables in the walk-in freezer in the main kitchen was not labeled.

Plan of Correction ***Accept [redacted] - 09/29/2025)***

The Community acknowledges the citation under 2800.103(e) regarding labeling and dating of leftover food. On 7/29/25, five pieces of cake, a bowl of egg salad, a bowl with cut lemons, and a bag of oriental vegetables in the walk-in freezer were found unlabeled and undated. While these items were not reused or served, they were not marked in accordance with regulatory requirements.
Corrective action was taken immediately to dispose of all unlabeled food items. On 9/30/25, the Culinary Services Director re-educated all dietary staff on proper labeling and dating of all leftover food, regardless of intended reuse. Staff were instructed that failure to label and date items would result in disciplinary action.
To prevent recurrence, the Culinary Services Director has implemented daily kitchen checks to verify that all items are labeled and dated. Documentation of these checks will be maintained, and findings will be reviewed weekly by the Executive Director for the next 60 days. Ongoing monitoring will occur through monthly audits and review during Quality Assurance meetings to ensure sustained compliance.
All corrective actions will be fully implemented by 10/30/25, with the Culinary Services Director and Executive Director responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Implemented [redacted] - 11/18/2025)

103g Storing food

18. Requirements

2800.
103.g. Food shall be stored in closed or sealed containers.

103g Storing food *(continued)*

Description of Violation

On 7/29/25, at approximately 11:00 a.m., a bag of cereal, on the steel shelves in the kitchen, was unsealed.

Plan of Correction ***Accept [redacted] - 09/29/2025)***

Corrective action was taken immediately as the bag of cereal was properly sealed and stored. On 9/30/25 all culinary staff were re-educated on the requirement that all food must be kept in closed or sealed containers at all times to prevent contamination.
To prevent recurrence, the Culinary Services Director has implemented daily visual checks of dry storage areas to ensure all items remain properly sealed. Results will be documented and reviewed weekly by the Executive Director for the next 60 days, then monthly thereafter. Any noncompliance will result in immediate corrective action.
All corrective actions will be completed by 10/30/25, with the Culinary Services Director and Executive Director responsible for sustained compliance.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] - 11/18/2025)

105g Dryer lint removal

20. Requirements

2800.
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 7/29/25, at approximately 12:05 p.m., there was an accumulation of lint in the following empty dryers in the second-floor laundry room, to include:

A golf ball size accumulation of lint in the 1st dryer on the right

An accumulation of lint in the trap holder of the 3rd dryer on the right

An accumulation of lint in the trap holder of the 4th dryer on the right

REPEAT VIOLATION: 6/27/24 et al

Plan of Correction ***Accept [redacted] - 09/29/2025)***

Corrective action was taken immediately on the date of citation as all lint traps were emptied, and the dryers were placed back into service only after being verified clean and safe. No residents or staff were harmed as a result of this deficiency.
To prevent recurrence, all caregivers, housekeepers, and maintenance team members were re-educated on 9/30/25, regarding the requirement to clean lint traps after each use and to document completion as part of laundry tasks. A new log has been implemented to track lint trap cleaning with supervisory spot checks conducted daily by the

105g Dryer lint removal (continued)

Maintenance Director or designee.
Ongoing compliance will be monitored through weekly audits of the log and random visual inspections of dryers by the Executive Director. Findings will be reviewed at monthly Quality Assurance meetings to ensure sustained compliance and identify any trends.
All corrective actions will be completed by 10/30/25, with the Executive Director and Maintenance Director responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Implemented [redacted] - 11/18/2025)

123b Emerg. procedures posted

21. Requirements

2800.
123.b. Copies of the emergency procedures as specified in § 2800.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the residence and a copy shall be kept.

Description of Violation

On 7/29/25, the residence's emergency preparedness plan for the local municipality and the residences emergency procedure and plan were both located in the Health Room on the first floor, which is not in a conspicuous and public place.

Plan of Correction ***Accept [redacted] - 10/08/2025)***

The Community respectfully contests the violation cited under 2800.123(b). The citation indicates that the emergency preparedness plan for the local municipality and the residence's emergency procedures were located in the Health Room on the first floor and therefore not posted in a conspicuous and public place. At the time of survey, the binder was temporarily in the Health Room while updates were being made to the emergency plan.

Once the updates were completed, the binder was returned to its designated location in the vestibule, where it is kept in a dedicated and clearly labeled holder for staff, residents, visitors, and surveyors to access. The binder has consistently remained in this location except for short periods of time when it is updated.
The Community maintains that it is in compliance with 2800.123(b), as the emergency preparedness plan and procedures are posted in a conspicuous and public location, and were only temporarily relocated for administrative purposes during the update process.
During the inspection, the Executive Director or designee immediately ensured that the Emergency Preparedness Binder was placed in a conspicuous and easily accessible location within the community. To prevent recurrence, the management team was educated on September 30, 2025, regarding the requirement to maintain the Emergency Preparedness Binder in its designated location at all times and to promptly notify the Executive Director or designee if it is not present. The Executive Director or designee will verify the binder's placement during monthly environmental rounds to ensure continued compliance. All corrective actions will be completed by October 30, 2025, with the Executive Director responsible for implementation and ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Implemented [redacted] - 11/18/2025)

132c Fire drill records

22. Requirements

132c Fire drill records *(continued)*

2800.
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 residence 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 held on 9/30/24 at 4:08 p.m. did not indicate the number of residents evacuated.

The fire drill record for the drill held on 11/27/24 at 12:15 p.m. did not indicate the number of residents in the residence at the time of the drill.

The fire drill record for the drill held on 2/18/25 at 4:35 p.m. did not indicate the number of residents evacuated and the number of residents in the residence at the time of the drill.

The fire drill record for the drill held on 4/30/25 did not indicate the time the drill was held beyond the first shift.

The fire drill record for the drill held on 7/18/25 at 12:02 p.m. did not indicate the number of residents evacuated and the number of residents in the residence at the time of the drill.

Plan of Correction ***Accept [redacted] - 09/29/2025)***

Corrective action was taken immediately. On 9/25/25, all fire drill records were reviewed, and missing information was corrected where available. Staff responsible for conducting fire drills were re-educated on 8/10/25 regarding the requirements for accurate and complete documentation, including the date, time, length of drill, exit route, number of residents in the residence at the time of the drill, number evacuated, number of staff participating, any problems encountered, and confirmation that the fire alarm or smoke detectors were operative.
To prevent recurrence, a revised fire drill record form was implemented that clearly lists all required fields and cannot be submitted with incomplete information. The Executive Director will review each fire drill record for accuracy and completeness within 24 hours of the drill. In addition, quarterly audits will be conducted by the Health and Wellness Director to verify that all drills are conducted across shifts and that records are complete.
All corrective actions will be completed by 10/30/25, with the Executive Director and Health and Maintenance Director responsible for sustained compliance.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] - 11/18/2025)

132d Evacuation

23. Requirements

2800.
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 residence.

132d Evacuation *(continued)*

Description of Violation

18 minutes, 0 seconds is the residence's maximum evacuation time determined by a fire safety expert on 8/20/24. The residence exceeded this time on 6/25/25 at 5:00 a.m. with an evacuation time of 23 minutes, 0 seconds.

Not all residents in the residence at the time of the following fire drills evacuated to a fire safe area or designated meeting place away from the building:

6/25/25 at 5:00 a.m. 44 residents, 17 evacuated

6/27/25 5:30 a.m. 44 residents, 17 evacuated

Plan of Correction ***Accept [redacted] - 09/29/2025)***

Residents were accounted for during both drills, and staff completed a follow-up review with the fire safety expert to identify barriers that contributed to the extended evacuation time and partial evacuations. The fire safety expert recommended adjustments to staffing assignments during drills, including pre-positioning team members at key exits and assigning additional staff to assist residents with mobility needs. These recommendations have been implemented.
To prevent recurrence, staff were re-educated on 8/10/25 regarding their specific roles during fire drills, including ensuring all residents are moved to the designated fire-safe area within the required timeframe. Future drills will include full evacuation of all residents present, unless a physician's order indicates otherwise. A revised drill procedure checklist was implemented to ensure consistency.
Monitoring will occur through Executive Director review of each fire drill record, including evacuation times and resident participation, within 24 hours of each drill. The Health and Wellness Director will also conduct quarterly audits of fire drill performance, and all findings will be reviewed during monthly Quality Assurance meetings. The Community will continue to engage the fire safety expert annually to evaluate evacuation procedures and update the maximum allowable evacuation time as required.
All corrective actions will be fully implemented by 10/30/25, with the Executive Director and Health and Wellness Director responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Implemented [redacted] - 11/18/2025)

132e Fire drill - sleeping hours

24. Requirements

2800.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

Sleeping hour fire drills were held on 6/24/24 at 10:56 p.m. and 2/13/25 at 6:14 a.m. More than 6 months transpired between sleeping hours fire drills.

132e Fire drill - sleeping hours (continued)

REPEAT VIOLATION: 1/9/25 et al

Plan of Correction ***Accept [redacted] - 09/29/2025)***

Corrective action has been taken to ensure sleeping hour fire drills occur within the required timeframe. A revised fire drill calendar was created on 8/10/25 to schedule all drills, including sleeping hour drills, in advance. The calendar includes reminders set for the Executive Director and the Health and Wellness Director to prevent lapses. In addition, sleeping hour drills are now tracked separately on the drill log to highlight the six-month compliance interval.
To prevent recurrence, the Executive Director will be responsible for ensuring that at least one sleeping hour drill is conducted in each six-month period, and results will be reported in monthly Quality Assurance meetings. The revised calendar and oversight process will ensure no interval exceeds six months going forward.
All corrective actions will be fully implemented by 10/30/25, with the Executive Director and Maintenance Director responsible for compliance

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] 11/18/2025)

132i Testing fire alarm

25. Requirements

2800.
132.i. A fire alarm or smoke detector shall be set off during each fire drill.

Description of Violation

The fire drill record indicated fire drills were conducted on 9/30/25 at 4:08 p.m. and 4/30/25 on the first shift; however, the fire drill record does not indicate if the alarm was activated. Additionally, it indicated the smoke detectors were not tested during this drill.

Plan of Correction ***Accept [redacted] - 09/29/2025)***

To correct this, staff responsible for conducting fire drills were re-educated on 8/10/25 regarding the requirement to activate the fire alarm or smoke detector during each drill and to document it consistently. A revised fire drill log sheet will be created by 9/30/25 that includes a mandatory field for fire alarm activation and smoke detector testing, ensuring completeness of documentation.
To prevent recurrence, the Executive Director will review each fire drill record within 24 hours of the drill to verify accuracy and completeness. Executive Director will audit all fire drill logs quarterly, and results will be reviewed during monthly Quality Assurance meetings.
All corrective actions will be fully implemented by 10/30/25, with the Executive Director and Maintenance Director responsible for sustained compliance.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Implemented [redacted] - 11/18/2025)

181c Self-Administer Assessment

26. Requirements

2800.

181c Self-Administer Assessment *(continued)*

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2800.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

The assessment for resident #8, dated [redacted]/25, was not updated to reflect [redacted] ability to self-administer some medications, to include inhalers, as reflected on [redacted] medical evaluation, dated [redacted]/25.

Plan of Correction ***Accept ([redacted] - 09/29/2025)***

The Health and Wellness Director will review and update Resident's service plan to include the Resident's abilities to self-administer PRN inhaler by 10-1-25.

To correct this, Resident #8's assessment and support plan were updated on 9/26/25 to accurately reflect [redacted] ability to self-administer medications as outlined by [redacted] medical provider. The Health and Wellness Director reviewed the resident's medical record and ensured the updated information was incorporated into the assessment and support plan.

To prevent recurrence, all licensed nurses and the Health and Wellness Director were re-educated on 9/11/25 regarding the requirement to update resident assessments and support plans promptly when new medical evaluations indicate changes in self-administration status. A new process has been implemented requiring licensed nurses to review all external medical evaluations within 48 hours of receipt and document any necessary updates to assessments and support plans.

Ongoing monitoring will occur through monthly chart audits completed by the Health and Wellness Director, with results reported at the Quality Assurance meeting. Any discrepancies between medical evaluations and assessments will be immediately corrected.

All corrective actions will be fully implemented by 10/30/25, with the Health and Wellness Director responsible for oversight and sustained compliance.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] - 11/18/2025)

184a Resident meds labeled

28. Requirements

2800.
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

On 7/30/25, resident #7 was prescribed Alprazolam 0.5mg, 2 tablets twice daily and every 6 hours as needed for anxiety; however, the label did not include the as needed order.

On 7/30/25, there were no pharmacy labels on the following medications prescribed to resident #8:
Lispo Inj 100/ml, inject subcutaneously before meals and at bedtime per sliding scale four times daily: 61-200=0, 201-250=3, 251-300=6, 301-350=9, 351-400= 12 units. Call MD if BS<60 or >400. Max 48 units daily. However, there was no label on the plastic bag in which this medication was stored in.

Lantus Solos inj 100/ml, inject every morning 35 units subcutaneously; however, there was no label on the plastic bag in which this medication was stored in.

REPEAT VIOLATION: 4/9/25

Plan of Correction ***Accept [redacted] - 09/29/2025)***

Corrective action was taken immediately. The pharmacy was contacted on 7/30/25, and corrected labels were issued for the affected medications were printed from the EHR. All medications in the cart and refrigerator were reviewed by the Health and Wellness Director to ensure labels included all required elements.
To prevent recurrence, all licensed nurses and medication-trained staff were re-educated on [insert date] regarding the requirement that all prescription medications be stored only in their original, pharmacy-labeled containers and

184a Resident meds labeled (continued)

that secondary storage bags must also contain appropriate labeling. Staff were reminded that any discrepancies in labeling must be reported to the Health and Wellness Director immediately for correction. The pharmacy partner has also been notified of this issue, and a verification process was established to confirm labels meet all regulatory requirements before medications are placed into use.

Ongoing monitoring will include weekly medication cart and refrigerator audits by the Health and Wellness Director or designee, with findings reported during monthly Quality Assurance meetings. Any labeling discrepancies will be corrected immediately in collaboration with the pharmacy.

All corrective actions will be fully implemented by 10/30/25 , with the Health and Wellness Director responsible for oversight and sustained compliance.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Implemented [redacted] - 11/18/2025)

185a Storage procedures

29. Requirements

2800.
185.a. The residence 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 7/30/25, resident #8 was prescribed Blood glucose checks four times daily as well as Lantus Solos inj 100/ml, inject every morning 35 units subcutaneously, and Lispo Inj 100/ml, inject subcutaneously before meals and at bedtime per sliding scale four times daily: 61-200=0, 201-250=3, 251-300=6, 301-350=9, 351-400= 12 units. Call MD if BS<60 or >400. Max 48 units daily. However, the following blood sugar readings present on the glucometer but were not recorded on the medication administration record (MAR):

Date & Time	***Glucometer Reading***
7/27/25 at 9:34 p.m.	*277*
7/26/25 at 11:58 a.m.	*158*

Plan of Correction ***Accept [redacted] - 09/29/2025)***

The MAR for Resident #8 was reviewed on 7/30/25, and nursing staff involved in care were counseled to ensure that all glucometer readings and insulin administrations are recorded in real time on the MAR. The Health and Wellness Director conducted a chart audit for all residents requiring blood glucose monitoring to confirm complete documentation.

To prevent recurrence, all licensed nurses and medication-trained staff were re-educated on 8/21/25 and 10/16/25 regarding the requirement to document all blood glucose readings and corresponding medication administrations at the time they occur. A revised documentation policy was implemented requiring cross-checks between the glucometer logs and the MAR once per shift. Additionally, glucometer download audits will be performed weekly by the Health and Wellness Director or designee to verify that all readings are documented appropriately in the MAR.

Ongoing monitoring will occur through monthly Quality Assurance reviews, where medication administration documentation compliance will be reported and trends addressed. Any future discrepancies will be corrected immediately, with retraining provided as needed.

All corrective actions will be fully implemented by 10/30/25, with the Health and Wellness Director responsible for

185a Storage procedures (continued)

oversight and sustained compliance.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] - 11/18/2025)

187b Date/time of med admin

31. Requirements

2800.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #12 was prescribed Mirtazapine 15mg, 1 tablet by mouth at bedtime. On 7/11/25, direct care staff person D signed off as administering this medication; however, an incident submitted to the Department indicates this medication was never administered.

Plan of Correction ***Accept [redacted] - 09/29/2025)***

The staff member involved was no longer employed at the Community at the time the error was identified. Med passers were provided re-education regarding the seriousness of accurate documentation and the prohibition against recording medication administration unless the medication has physically been provided to the resident on 07/11/2025. The missed dose was reported, the prescribing physician was notified, and monitoring of the resident was completed with no adverse outcomes noted.
To prevent recurrence, all licensed nurses and medication-trained staff were re-educated on 8/21/25 and 10/16/25 regarding the requirement to document medication administration in real time and only after the medication has been given. Emphasis was placed on avoiding "pre-charting" or documenting without completing the task. The eMAR system settings were also reviewed, and an additional verification step was reinforced during orientation and ongoing competency training.
Ongoing monitoring will occur through weekly random audits of medication administration records by the Health and Wellness Director, including cross-checks with incident reports. Any discrepancies will be corrected immediately, with retraining or disciplinary action as appropriate. Results will be reviewed in monthly Quality Assurance meetings. All corrective actions will be fully implemented by 10/30/25, with the Health and Wellness Director responsible for oversight and sustained compliance.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] - 11/18/2025)

187d Follow prescriber's orders

32. Requirements

2800.
187.d. The residence shall follow the directions of the prescriber.

Description of Violation

Resident #12 was prescribed Mirtazapine 15mg, 1 tablet by mouth at bedtime; however, on 7/11/25, this medication was not administered.

REPEAT VIOLATION: 12/12/24 et al, 11/22/24, 4/9/25, 3/14/25, 1/9/25 et al

187d Follow prescriber's orders (continued)

Plan of Correction ***Accept [redacted] - 10/08/2025)***

The Community respectfully disputes this citation as duplicative of the previously cited deficiency under 2800.187(b) (Date/Time of Medication Administration). Both citations refer to the same isolated incident on 7/11/25 regarding Resident #12's prescribed Mirtazapine 15 mg at bedtime.
The deficiency under 2800.187(b) already addresses the missed administration and corresponding documentation error. Issuing a separate citation under 2800.187(d) for the same occurrence results in duplicate findings for the same event, which is not consistent with fair survey practice.
The Community has already acknowledged the deficiency under 2800.187(b) and provided a corrective action plan addressing both the missed administration and the documentation process. This plan includes staff re-education, revised policies, and enhanced monitoring to ensure all prescriber orders are followed and medications are documented in real time.
We respectfully request that this citation under 2800.187(d) be rescinded as duplicative.

Med passers were provided re-education regarding the seriousness of accurate documentation and the prohibition against recording medication administration unless the medication has physically been provided to the resident on 07/11/2025. The missed dose was reported, the prescribing physician was notified, and monitoring of the resident was completed with no adverse outcomes noted.
To prevent recurrence, all licensed nurses and medication-trained staff were re-educated on 8/21/25 and 10/16/25 regarding the requirement to document medication administration in real time and only after the medication has been given. Emphasis was placed on avoiding "pre-charting" or documenting without completing the task. The eMAR system settings were also reviewed, and an additional verification step was reinforced during orientation and ongoing competency training.
Ongoing monitoring will occur through weekly random audits of medication administration records by the Health and Wellness Director, including cross-checks with incident reports. Any discrepancies will be corrected immediately, with retraining or disciplinary action as appropriate. Results will be reviewed in monthly Quality Assurance meetings. All corrective actions will be fully implemented by 10/30/25, with the Health and Wellness Director responsible for oversight and sustained compliance.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Implemented [redacted] - 11/18/2025)

227d Support plan – med/dental

34. Requirements

2800.
227.d. Each residence shall document in the resident's final support plan the dietary, medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

Description of Violation

The support plan for resident #8, dated [redacted]/25, did not address the resident's use of home health care and catheter care.

227d Support plan – med/dental *(continued)*

Plan of Correction ***Accept [redacted] - 09/29/2025)***

Resident #8's support plan was updated on 9/26/25 to include home health care services and catheter care. The Health and Wellness Director reviewed the resident's medical records and coordinated with the home health provider to ensure all services were accurately reflected in the plan.
To prevent recurrence, all licensed nurses and the Health and Wellness Director were re-educated on 9/11/25 regarding the requirement to include all outside medical, dental, and behavioral health services in each resident's support plan. A new support plan review checklist has been implemented, requiring verification that external services are identified and documented.
Ongoing monitoring will occur through 10% of the census chart audits conducted monthly by the Health and Wellness Director, with results reviewed at Quality Assurance meetings. Any omissions identified will be corrected immediately, and staff will be retrained as needed.
All corrective actions will be fully implemented by 10/30/25, with the Health and Wellness Director responsible for oversight and sustained compliance.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Implemented [redacted] - 11/18/2025)

Facility Information

Name: *WESTLAKE WOODS AL* **License #**: *45407* **License Expiration**: *10/31/2025*

Address: *3302 WEST LAKE ROAD, ERIE, PA 16505*

County: *ERIE* **Region**: *WESTERN*

Administrator

Name: [redacted]

Legal Entity

Name: *ERIE OPS LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/31/1997* **Issued By**: *Dept. of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *54* **Waking Staff**: *41*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *10/02/2025*

Inspection Dates and Department Representative

09/04/2025 - On-Site: [redacted]

10/02/2025 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *79* **Residents Served**: *40*

Special Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *40*

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

Have Mobility Need: *14* **Have Physical Disability**: *2*

Inspections / Reviews

09/04/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/01/2025*

11/10/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/10/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/13/2025*

Inspections / Reviews *(continued)*

11/13/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/10/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/06/2025*

42b Abuse/Neglect

1. Requirements

2800.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 8/4/25 at approximately 10:00 p.m., resident #1 sustained an unwitnessed fall in [redacted] apartment and was unable to reach [redacted] call bell. The resident yelled for help for several hours, while lying face down on [redacted] bedroom floor. At approximately 5:00 a.m., staff person A arrived to administer resident #1's medication, and found the resident face down on the floor, soaked in urine, and crying. Resident #1 reported [redacted] had pain in [redacted] arms and knee, nausea from lying on [redacted] stomach, and was very thirsty. Staff person A attempted to call the 3 other staff persons on duty over the walkie talkie for assistance and received no response. Staff person A then called 911, and continued trying unsuccessfully to reach the other 3 staff persons over the walkie talkie, and pushed resident #1's call bell to alert the other 3 staff that she needed assistance; however, they did not respond. Staff person A asked resident #1 if [redacted] wanted help to try and roll on [redacted] side and the resident agreed; however, as soon as staff person A touched resident #1, [redacted] screamed out in pain. Approximately 10 minutes later, the 3 other staff arrived at resident #1's apartment along with 2 paramedics. Staff person B and staff person C indicated they had their walkie talkies; however, they were turned off.

The paramedics attempted to move resident #1 but [redacted] screamed out in pain, was shaking and crying, and said [redacted] could not move [redacted] arms. Staff attempted to utilize a Hoyer Lift to move resident #1 and were unable to, thus paramedics contacted the fire department for assistance. Several members of the fire department arrived and were able to assist the resident from the floor. Resident #1 was transported via ambulance to the local hospital, where [redacted] was diagnosed with bilateral shoulder fractures. On 8/7/25, resident #1 was transferred to a higher level of care at a Pittsburgh Hospital. On 8/24/25, resident #1 was discharged to a skilled nursing facility.

Repeat Violation: 1/9/25 et al., 11/22/24

Plan of Correction ***Directed [redacted] - 11/13/2025)***

Immediate: Team members involved in the incident were [redacted] immediately pending investigation
Corrective Actions-Team members have since been [redacted]. Executive director or designee will retrain all direct care staff on 42b. by 11/14/25.
Preventative actions-Starting on 10-27,the Executive director or designee will complete Ongoing audits of 10% of new staff hired training on 42b and Residents rights weekly for four consecutive weeks or until compliance is achieved and then monthly thereafter. The Executive Director or designee will implement policy and procedures to ensure residents are routinely checked on in regular intervals throughout the night. Documentation of checks will be kept. The administrator will educate all staff on the policy and procedures. On 11/10/25 implantation and training was done by the Executive Director or designee and implementation of policy and procedures to ensure residents are routinely checked on in regular intervals throughout the night. The administrator will educate all staff on the policy and procedures. Results of audits and corrective actions will be documented and reviewed monthly during Quality Assurance and Improvement Committee meetings on 11/7/25 by the ED to support ongoing compliance
Overall completion date:11/28/25

Proposed Overall Completion Date: 11/28/2025

Directed:
By 12/4/25, weekly for 4 weeks, and monthly thereafter, the administrator or designee will privately interview 4

42b Abuse/Neglect (continued)

residents regarding their care and treatment from staff. Documentation will be kept and reviewed during monthly Quality Assurance and Improvement Committee meetings.

SQ 11/13/25

Directed Completion Date: *12/04/2025*

51 Criminal background checks

2. Requirements

2800.

51.a. Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

51.b. The hiring policies shall be in accordance with the Department of Aging's Older Adult Protective Services Act policy as posted on the Department of Aging's web site.

Description of Violation

Staff person B was hired on [redacted]24; however, a Pennsylvania State Police Criminal Background was not completed until 3/24/25.

Staff person C was hired on [redacted]/24; however, a Pennsylvania State Police Criminal Background was not completed until 2/25/25.

Plan of Correction ***Accept [redacted] - 11/10/2025)***

Immediate: Team members involved in the incident were [redacted] immediately pending investigation.
Corrective action-Team members have since been [redacted]. Area Director of Operations provided education to the ED or designee on completion of CBCs on 10/31/25.
Ongoing- All CBC's are current and up to date for new hires. The executive director or designee will complete ongoing audits of 10% of new staff hired staff weekly for four consecutive weeks or until compliance is achieved. Results of audits and corrective actions will be documented and reviewed monthly during Quality Assurance and Improvement Committee meetings by the ED to support ongoing compliance by 11/5/25.
Overall completion date- 11/28/25

Licensee's Proposed Overall Completion Date: *11/28/2025*

65g Initial direct care training

3. Requirements

2800.

65.g. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas:

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

3. Initial direct care staff person training to include the following:

xii. Safety management and hazard prevention.

Description of Violation

Direct care staff person C, [redacted]24, did not complete the Department approved direct care training course and passing of the competency test until 3/24/25.

65g Initial direct care training *(continued)*

Plan of Correction ***Accept (- 11/10/2025)***

Immediate: Team members involved in the incident were immediately pending investigation.
Corrective action-Team members have since been
Ongoing- Starting on 10/27, the executive director or designee will audit 10% of new hire education and direct care staff training weekly for four weeks or until compliance is achieved. Results of audits and corrective actions will be documented and reviewed monthly during Quality Assurance and Improvement Committee meetings by the ED to support ongoing compliance by 11/7/25.
Overall completion date 11/28/25

Licensee's Proposed Overall Completion Date: *11/28/2025*

90b Staff commnication

4. Requirements

2800.
90.b. For a residence serving nine or more residents, there shall be a system or method of communication that enables staff persons to immediately contact other staff persons in the residence for assistance in an emergency.

Description of Violation

On 8/4/25 at approximately 10:00 p.m., resident #1 sustained an unwitnessed fall in apartment and was unable to reach call bell. The resident yelled for help for several hours, while lying face down on bedroom floor. At approximately 5:00 a.m., staff person A arrived to administer resident #1's medication, and found the resident face down on the floor, soaked in urine, and crying. Resident #1 reported had pain in arms and knee, nausea from lying on stomach, and was very thirsty. Staff person A attempted to call the 3 other staff persons on duty over the walkie talkie for assistance and received no response. Staff person A then called 911, and continued trying unsuccessfully to reach the other 3 staff persons over the walkie talkie, and pushed resident #1's call bell to alert the other 3 staff that she needed assistance; however, they did not respond. Staff person A asked resident #1 if wanted help to try and roll on side and the resident agreed; however, as soon as staff person A touched resident #1, screamed out in pain. Approximately 10 minutes later, the 3 other staff arrived at resident #1's apartment along with 2 paramedics. Staff person B and staff person C indicated they had their walkie talkies; however, they were turned off.

The paramedics attempted to move resident #1 but screamed out in pain, was shaking and crying, and said could not move her arms. Staff attempted to utilize a Hoyer Lift to move resident #1 and were unable to, thus paramedics contacted the fire department for assistance. Several members of the fire department arrived and were able to assist the resident from the floor. Resident #1 was transported via ambulance to the local hospital, where she was diagnosed with bilateral shoulder fractures. On 8/7/25, resident #1 was transferred to a higher level of care at a Hospital. On 8/24/25, resident #1 was discharged to a skilled nursing facility.

Plan of Correction ***Accept - 11/13/2025)***

Immediate: Team members involved in the incident were immediately.
Corrective action-Team members have since been .
Ongoing- All direct care staff will be retrained on 90b by 11/14/25 by the Executive Director or designee. Starting on 11/10/25 The Executive Director or designee will spot check staff daily to verify staff have their communication devices on and that they are in working order at shift change. If team member is found without a communication device, reeducation and disciplinary actions will result. Results of audits and corrective actions will be documented and reviewed monthly during Quality Assurance and Improvement Committee meetings by the ED to support ongoing compliance by 11/7/25

90b Staff commnication (continued)

Overall completion date 11/28/25

Licensee's Proposed Overall Completion Date: *11/28/2025*