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

October 24, 2025

[redacted], PRESIDENT
THE PALMS AT O'NEIL INC
1 GLENSHIRE LANE
MCKEESPORT, PA, 15132

RE: THE PALMS AT O'NEIL
1 GLENSHIRE LANE
MCKEESPORT, PA, 15132
LICENSE/COC#: 43964

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/13/2025, 08/13/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE PALMS AT O'NEIL* **License #**: *43964* **License Expiration**: *11/19/2025*

Address: *1 GLENSHIRE LANE, MCKEESPORT, PA 15132*

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

Administrator

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

Legal Entity

Name: *THE PALMS AT O'NEIL INC*

Address: *1 GLENSHIRE LANE, MCKEESPORT, PA, 15132*

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *10/22/2008* **Issued By**: *City of McKeesport*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *91* **Waking Staff**: *68*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *08/14/2025*

Inspection Dates and Department Representative

08/13/2025 - On-Site: [redacted]

08/13/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *82* **Residents Served**: *68*

Secured Dementia Care Unit

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

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *3* **Are 60 Years of Age or Older**: *65*

Diagnosed with Mental Illness: *39* **Diagnosed with Intellectual Disability**: *3*

Have Mobility Need: *23* **Have Physical Disability**: *3*

Inspections / Reviews

08/13/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/25/2025*

10/01/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/16/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/06/2025*

Inspections / Reviews *(continued)*

10/08/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/16/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/15/2025*

10/24/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/16/2025*

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

3c - Post Current License

1. Requirements

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

Description of Violation

On 8/13/25, at approximately 9:50 AM, the Licensing Inspection Summary (LIS) from the home's most recent renewal, dated 4/16/24, and the LIS for a complaint/monitoring inspection, dated 7/23/24, were not posted in a public and conspicuous place in the home.

Plan of Correction ***Accept (- 10/08/2025)***

A copy of the most current inspection was hung outside the office for all to view by the administrator. This was completed on 8/13/25. A weekly inspection will take place by the office manager to ensure the most current inspections and current chapter are posted on the wall outside of the admin office. Documentation of this will be kept in the quality control book.
A form was made and kept in the Administrator's office. Office Manager to fill in the form weekly along with any correction made if needed. Copy of form attached.

Licensee's Proposed Overall Completion Date: *10/06/2025*

Implemented (- 10/24/2025)

63a - First Aid/CPR Training

2. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 7/27/25, the home had 63 residents present in the home. However, only one staff person trained in first aid and certified in obstructed airway techniques and CPR was present in the home from 11:30 p.m. – 6:00 a.m. on 7/28/25.

63a Repeat violation 4/16/24 et al

Plan of Correction ***Directed (- 10/08/2025)***

An audit of all staff PCA records was done by Staffing Manager to identify anyone without CPR being trained accordingly. A record book kept by the HR director will be submitted to the administrator monthly to ensure compliance. A copy of this record will be kept in the quality control book in the HR office. Copy of the checks for the PCA staff is attached.

Proposed Overall Completion Date: 10/06/2025

DIRECTED
Within one day of receipt of the plan of correction: The administrator or a designated staff person shall complete a weekly or biweekly schedule that includes at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR will be in the home at all times. 10/8/25

Within one day of receipt of the plan of correction: The administrator or a designated staff person shall complete a weekly review of the actual staff persons who worked in the home to ensure at least one staff person for every 50

63a - First Aid/CPR Training (continued)

residents who is trained in first aid and certified in obstructed airway techniques and CPR was in the home at all times. [redacted] 10/8/25

Directed Completion Date: *10/09/2025*

Implemented ([redacted] - 10/24/2025)

65e - 12 Hours Annual Training

3. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person A, hired [redacted] only completed 10 hours of annual training for the 1/1/24 – 12/31/24 staff training year.

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

An audit of all staff PCA records will be done to identify anyone without 12 hours of annual training and will be trained. A record book kept by the HR director will be submitted to the administrator monthly to ensure compliance. A copy of this record will be kept in the quality control book in the HR office. Copy of check list is attached to the completed of files. Copy of this check list to be attached. Administrator to have monthly meeting with the HR director to ensure that training is done for each month along with a copy of the sign in sheets to ensure that all staff has been trained.

Proposed Overall Completion Date: 10/31/2025

DIRECTED
Within five days of receipt of the plan of correction: Direct care staff person A shall complete two hours of training for the 2024 training year. Direct care staff person A shall complete an additional 12 hours of annual training during the 2025 training year. [redacted] 10/8/25

Directed Completion Date: *10/13/2025*

Implemented ([redacted] - 10/24/2025)

65g - Annual Training Content

4. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

Staff person A, hired [redacted], and staff person B, hired [redacted], did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during the 1/1/24 – 12/31/24 annual training year.

Plan of Correction ***Accept ([redacted] - 10/01/2025)***

Fire training was completed on 9-5-25 by MAFD. This included a drill along with fire extinguisher training. A record book kept by the HR director will be submitted to the administrator monthly to ensure compliance. A copy of this

65g - Annual Training Content (continued)

record will be kept in the quality control book in the HR office.

Licensee's Proposed Overall Completion Date: *10/15/2025*

Implemented (- 10/24/2025)

85a - Sanitary Conditions

5. Requirements

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

Description of Violation

On 8/14/25 at 3:20 p.m., there were water stains on three ceiling tiles in the corner of the ceiling above the toilet in the third-floor shower room near resident room #301. There was an area on one of the tiles that was blackened and appeared to be moldy.

Plan of Correction ***Directed (- 10/08/2025)***

The tiles were removed and replaced by housekeeping. The housekeeping department will conduct daily sweeps of the facility and identify any tile that appear to be damaged. They will report to the supervisor of housekeeping of any tiles needing replaced. The supervisor will report to maintenance via maintenance log so that the cause of the stain can be identified and addressed. Weekly checks to be completed by housekeeping. checks will be turned in to office manager and the office Manager to make work order for Maintenance to correct any issues. Copy of education given and form to be attached

Proposed Overall Completion Date: 10/31/2025

DIRECTED
Within five days of receipt of the plan of correction: The administrator shall educate all staff persons on Regulation 2600.85(a) and the home's policies and procedures, to maintain compliance. Documentation of education shall kept in accordance with Regulation 2600.65(i). 10/9/25

Directed Completion Date: *10/13/2025*

Implemented (- 10/24/2025)

101j2 - Bedroom Chairs

6. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
2. A chair for each resident that meets the resident's needs.

Description of Violation

On 8/14/25 at approximately 3:00 p.m., there was no chair in resident room #313 which is occupied by one resident.

Plan of Correction ***Directed (- 10/08/2025)***

The admissions manager will conduct an inspection of the room prior admission with the attached check list to ensure that all requirements are met prior to admission. A copy of this check list will be turned into the office manager and reported to maintenance for correction. A copy will be kept with the admission file. Housekeeping will conduct weekly checks during scheduled cleanings and report
any deficiencies on the maintenance log.

101j2 - Bedroom Chairs (continued)

Proposed Overall Completion Date: 10/31/2025

DIRECTED
Immediately: The administrator shall place a chair in resident room #313 that meets the resident's needs. [redacted] 10/8/25

Within five days of receipt of the plan of correction: The administrator shall educate all staff persons on Regulation 2600.101(j)(2) and the home's policies and procedures, to maintain compliance. Documentation of education shall kept in accordance with Regulation 2600.65(i). [redacted] 10/9/25

Directed Completion Date: *10/13/2025*

Implemented ([redacted] - 10/24/2025)

101j7 - Lighting/Operable Lamp

7. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 8/15/25, there was no operable lamp or other source of light that could be turned on at bedside in resident room #301.

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

The admissions manager will conduct an inspection of the room prior admission with the attached check list to ensure that all requirements are met prior to admission. A copy of this check list will be kept with the admission file. Copy of check list will be attached. Housekeeping will conduct daily checks of the room to ensure lamps are operable. If they are not they will replace the bulb and or report the issue to maintenance for repair.

Proposed Overall Completion Date: 10/31/2025

DIRECTED
Immediately: The administrator shall place an operable lamp or other source of lighting that can be turned on at bedside in resident room #301. [redacted] 10/8/25

Within five days of receipt of the plan of correction: The administrator shall educate all staff persons on Regulation 2600.101(j)(7) and the home's policies and procedures, to maintain compliance. Documentation of education shall kept in accordance with Regulation 2600.65(i). [redacted] 10/9/25

Directed Completion Date: *10/13/2025*

Implemented ([redacted] - 10/24/2025)

132b - Safety Inspection/Fire Drill

8. Requirements

2600.

132b - Safety Inspection/Fire Drill *(continued)*

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home's most recent fire safety inspection and fire drill conducted by a fire safety expert was on 6/20/24.

Plan of Correction ***Directed (- 10/08/2025)***

Fire training was scheduled and completed on 9-5-25 by MAFD.The administrator made this schedule. This included a drill along with fire extinguisher training. Staff was present and participated in the training.A record book kept by the HR director will be submitted to the administrator monthly to ensure compliance. A copy of this record will be kept in the quality control book in the HR office. Administrator will schedule fire safety within the first quarter of each year. This will be placed in the quality control book along with the schedule of all 12 yearly training and the date that they are scheduled.. copy of sign in sheet for the 9/5/2025 training will be attached.

Proposed Overall Completion Date: 10/31/2025

DIRECTED
Within five days or receipt of the plan of correction: The administrator shall have a fire safety inspection and fire drill conducted by a fire safety expert. Documentation shall be kept. 10/8/25

Directed Completion Date: *10/13/2025*

Implemented (- 10/24/2025)

132f - Alternate Exit Routes

9. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

All of the fire drills conducted by the home from 4/25/24 through 7/15/25 indicate that the exit routes used are "All."

Plan of Correction ***Directed (- 10/08/2025)***

The home will rotate closing off exit sites to ensure alternate sites are taken. The homes administrator will document the blocked and alternate sites on the fire drill log monthly. The Administrator will be responsible to setting up the fire drills, place the information of the fire drill on the form, list the exit used, and the Office Manager will be responsible to check the fire drill record monthly to ensure that all information is on the form and that exists are being rotated. Administrator gave Office Manager training and sign in sheet along with fire drill record will be attached.

Proposed Overall Completion Date: 10/31/2025

DIRECTED
Within five days of receipt of the plan of correction: The administrator shall educate all staff persons on Regulation 2600.132(f) and the home's policies and procedures, to maintain compliance. Documentation of education shall kept in accordance with Regulation 2600.65(i). 10/9/25

Within one day of receipt of the plan of correction: The administrator shall monitor the home's fire drill record

132f - Alternate Exit Routes (continued)

monthly to ensure compliance with Regulation 2600.132(f). [redacted] *10/8/25*

Directed Completion Date: *10/13/2025*

Implemented ([redacted] - 10/24/2025)

141a 1-10 Medical Evaluation Information

10. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

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

Description of Violation

Resident #1's initial medical evaluation (DME) completed [redacted] *did not include a medication regimen. The medication section was blank and there was no documentation attached to the DME.*

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

All DMEs will be reviewed and signed off on by the Wellness Director as a second check (first check being delegated staff responsible for reviewing DMEs initially) upon completion by the provider prior to being filed in the resident's chart. The Wellness Director will initial the DME noting review. Director of wellness checked all the DME's to ensure that they are completed in the time allotted for them.

Starting 10/6/2025 the assistant to the Director of Wellness to check monthly to ensure that DME's are placed in the residents chart, was completed in a time that it is due. Training will be given to the Director of Wellness and assistant to the Director by the Administrator on 10/6/2025

Proposed Overall Completion Date: 10/31/2025

DIRECTED

Within 5 days of receipt of the plan of correction: The administrator shall have resident #1's initial medical evaluation (DME) completed 1/7/25 updated in accordance with the guidance in the PA BHSL Regulatory Guidance Guide. [redacted] *10/8/25*

Directed Completion Date: *10/13/2025*

Implemented ([redacted] - 10/24/2025)

183b - Meds and Syringes Locked

11. Requirements

2600.

183b - Meds and Syringes Locked *(continued)*

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 8/14/25 at 2:57 p.m., there was an inhaler with a worn off label setting in a basket on the nightstand by resident #2's bed near the window in the unlocked, opened resident room

Plan of Correction ***Directed (- 10/08/2025)***

Resident #2 has been assessed by The Palms DOW as unable to safely self-administer medications as well as indicated on DME by the provider.
Resident #2 has been verbally educated on not being permitted to have any medications on person or in room due to the state regulations and DOW assessment of inability to safely self medicate or manage medications. This is also indicated on RASP under the medication assessment section and includes the risk for non-compliance. Emailed documentation of the verbal education and Resident #2 responses from the conversation are include for review dated 11-30-2021 and 12-2-2021. No further reports have been made since the documented verbal education and conversation expecting compliance.
is currently on a 30 day notice issued on and placement agency has been attempting to find placement elsewhere and have thus been unsuccessful.
It is against resident rights to go through resident belongings without their permission. has refused to allow the DOW to go through room and belongings at this time to ensure doe snot have any other medicatons in possession. denies having any inhalers or medications in room or on person at this time. The DOW, again, verbally educated and stressed to the resident that per DOW assessment and state regulation and Provider's assessment, is not assessed as being able to safely store or manage medications Resident #2 currently verbalizes understanding at this time. Resident is at risk for future non-compliance. The 30 day notice will remain in effect for this reason. Resident is capable of leaving the home unattended and does go to the local stores and has the ability to purchase anything desires without notifying the home.
Designated staff will perform checks of Resident #2 room monthly. Designated staff will request permission from Resident #2 to search room and belongings for medications prior to search. Documentation will be kept of any medications found. Documentation of any medications removed from room or from possession with permission (due to resident rights) will be kept. Documentation of refusals will be kept. Follow-ups will be made with the placement agency attempting to find other placement will be done monthly and documentation of the correspondence will be kept.
Audit of all resident's rooms will start on October 13, 2025 and will be done monthly by the Director of Wellness. The form will have the resident name, date, sweep of residents room and if any medication is found or not. The resident will again be educated on medication being allowed in the rooms or not. First offense will be a written warning. 2nd offense will result in a notice to vacate the facility.A copy of the policy will be attached along with the DOW signed copy of understanding. Forms of audits will be kept in DOW office in a binder.

Proposed Overall Completion Date: 10/31/2025

DIRECTED
Within five days of receipt of the plan of correction: The administrator shall educate all staff persons on Regulation 2600.183(b) and the home's policies and procedures, to maintain compliance. Documentation of education shall kept in accordance with Regulation 2600.65(i). 10/9/25

Directed Completion Date: *10/13/2025*

Implemented (- 10/24/2025)

184a - Resident's Meds Labeled

12. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
2. The name of the medication.

Description of Violation

On 8/14/25, resident #3's August 2025 medication administration record (MAR) had an entry for "anti-diarrheal 2mg caplet – take one tablet by mouth four times a day as needed. Equiv to Imodium A-D 2mg caplet." However, there was a bottle of this medication with a pharmacy label that only indicated "Loperamide 2mg caplet – take one capsule by mouth four times daily as needed."

184a Repeat violation 4/16/24 et al

Plan of Correction ***Accept ([redacted] - 10/01/2025)***

Resident #3 MAR was updated on the same day as it was discovered by the inspector to include the medication equivalent name for staff to recognize other names for same medication. Staff delegated to approve medications in the QUICK MAR will be re-educated on checking for equivalent names entered into QUICK MAR. RE-education for all med passers will be completed within 1 week to include procedure for checking in medications prior to placing them into the med carts via checking the label with the MAR entry. Any discrepancy will hault the med passer from placing the medication in the med cart, notification will be given to management and the medication label and QUICK MAR entry will be reviewed by management upon discovery. Appropriate corrections will be made prior to placing the medication in the cart for dispensing by the med passers.

Licensee's Proposed Overall Completion Date: *10/02/2025*

Implemented ([redacted] - 10/24/2025)

191 - Resident Right to Refuse

14. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #5 was admitted to the home on [redacted] However, there was no documentation in resident #5's record that the resident was educated on the right to question or refuse a medication if the resident believes there may be a medication error.

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

The home printed an old copy of the resident rights into the homes contract that is reviewed and signed at admission. This copy was permanently deleted. Each resident file will be reviewed for the correct copy. Any files found with the incorrect document will be given the correct copy and signed by that resident. A copy of this shall be attached to their resident home contract. The admissions manager will review the contract for correctness quarterly. The admissions Manager will check all the resident contracts and correction will be made to any record that did not have resident right to refuse medication in the resident rights and placed in the residents chart. Copy of the check sheet will be attached when the check is complete

191 - Resident Right to Refuse (continued)

Proposed Overall Completion Date: 10/31/2025

DIRECTED
Within one day of receipt of the plan of correction: The administrator shall educate resident #5 of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept. 10/8/25

Directed Completion Date: *10/13/2025*

Implemented ([redacted] - 10/24/2025)

251b - Record Entries Legible

15. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on resident #4's annual medical evaluation completed [redacted] The correction fluid was used in the medication section where it indicates whether or not the resident is able to self-administer each medication.

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

Resident #4 DME was completed by [redacted] provider. The correction was made prior to the provider completing and signing the DME therefore there was no correction date and time added since it was the same as the date and signature on the DME provider completion page. Correction fluid will not be used by The Palms staff on any DME documents. The designated person responsible for reviewing the DMEs will require the form to be corrected appropriately without correction fluid or re-done by the provider. The DME for Resident #4 will be appropriately updated and re-done upon return to The Palms as he is currently out of the facility.
Policy and procedure was entered in the nursing dept. Training Manual and training of all nursing staff of this policy will be completed by 10/31/2025.RN and Lpn was trained on 10/7/2025 and copy of the policy will be kept in binder in the DOW office. Copy of sign in sheet of the 10/31/2025 will be attached after the education that is scheduled

Proposed Overall Completion Date: 10/31/2025

DIRECTED
within five days of receipt of the plan of correction: The administrator shall ensure all staff have received the training related to regulation 2600.251(b). [redacted] 10/8/25

Directed Completion Date: *10/13/2025*

Implemented ([redacted] - 10/24/2025)