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

October 15, 2025

[redacted]
ASBURY VILLAS
[redacted]

RE: ASBURY VILLAGE AND PLACE LLC
730 BOWER HILL
PITTSBURGH, PA, 15243
LICENSE/COC#: 45554

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/09/2025 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: *ASBURY VILLAGE AND PLACE LLC* **License #**: *45554* **License Expiration**: *04/01/2026*

Address: *730 BOWER HILL, PITTSBURGH, PA 15243*

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

Administrator

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

Legal Entity

Name: *ASBURY VILLAS*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/19/2002* **Issued By**: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *65* **Waking Staff**: *49*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *09/09/2025*

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *65*

Secured Dementia 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**: *65*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *0* **Have Physical Disability**: *1*

Inspections / Reviews

09/09/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/11/2025*

10/06/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/14/2025*

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

Inspections / Reviews *(continued)*

10/09/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *10/14/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *10/14/2025*

10/15/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *10/14/2025*

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

23a Activities of Daily Living Assistance

1. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident [redacted] annual support plan, dated [redacted] indicated that "direct care staff are to remind the resident to turn and reposition while in chair and bed Q2 hours." Resident [redacted] support plan clearly indicates that the resident has short term and long-term memory deficit. In addition, the physician order dated [redacted] stated, "Per wound care expert's recommendations. Turn resident to right or left side every 2 hours during the night to relieve the pressure on wound. Use pillows to help turn resident five times a day." However, the following direct care staff personnel did not turn resident [redacted] every 2 hours on the following dates and times as per the physician's order:

- *On [redacted] direct care staff person A, did not turn resident [redacted] during the night from approximately 12:00 a.m. to 05:56 a.m.*
- *On [redacted] direct care staff person B, did not turn resident [redacted] during the night from approximately 12:00 a.m. to 05:38 a.m.*
- *On [redacted] direct care staff person C, did not turn resident [redacted] during the night from approximately 12:00 a.m. to 03:21 a.m.*
- *On [redacted] direct care staff person B, did not turn resident [redacted] during the night from approximately 12:00 a.m. to 06:00 a.m.*
- *On [redacted] direct care staff person C, did not turn resident [redacted] during the night from approximately 12:00 a.m. to 01:40 a.m., and from approximately 04:00 a.m. to 05:55 a.m.*
- *On [redacted] direct care staff person C, did not turn resident [redacted] during the night from approximately 02:00 a.m. to 05:31 a.m.*
- *On [redacted] direct care staff person B, did not turn resident [redacted] during the night from approximately 02:00 a.m. to 05:31 a.m.*
- *On [redacted] direct care staff person A, did not turn resident [redacted] during the night from approximately 12:00 a.m. to 05:33 a.m.*
- *On [redacted] direct care staff person B, did not turn resident [redacted] during the night from approximately 12:00 a.m. to 06:28 a.m.*
- *On [redacted] direct care staff person B, did not turn resident [redacted] during the night from approximately 12:00 a.m. to 06:18 a.m.*
- *On [redacted] direct care staff person B, did not turn resident [redacted] during the night from approximately 12:00 a.m. to 06:15 a.m.*
- *On [redacted] direct care staff person C, did not turn resident [redacted] during the night from approximately 02:00 a.m. to 06:28 a.m.*

Plan of Correction ***Accept ([redacted] 10/06/2025)***

-9/9/25 - Administrator educated staff on the importance of following the support plans for each resident's ADL needs and should immediately document the care provided.
-10/2/25 - Administrator/LPN to verify with MD that this order continues to be appropriate for resident [redacted]s needs
-10/2/25 and 10/3/25 - Administrator conducted in-service for all staff to emphasize importance in assisting residents with ADL's as indicated in the resident assessment support plan. Documentation of completion of training will be kept in accordance with 2600.65i.
-9/11/25 –9/26/25- Administrator completed audit of all resident assessment support plans to ensure they are

23a Activities of Daily Living Assistance (continued)

accurately representing what ADL's residents need assistance with.

10/1/25 Administrator/designee will audit 10 resident RASP's monthly including new admissions as they occur, to ensure all resident assessment support plans are accurate and followed. Audit will be ongoing.

Beginning 10/1/25, Administrator will privately interview 5 resident's weekly for 3 months (until 01/01/26) and 5 residents monthly thereafter, to ensure compliance with 2600.23(a)

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

Implemented - 10/15/2025)

187d - Follow Prescriber's Orders

2. Requirements

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

Description of Violation

Residents of the home were not administered multiple medications as prescribed:

- *Resident is prescribed give 1 tablet by mouth at bedtime for at 8:00 p.m., however the medication was not administered timely on*
- *Resident is prescribed give 1 tablet by mouth two times a day for at 8:00 p.m., however the medication was not administered timely on*
- *Resident is prescribed give 1 tablet by mouth at bedtime for at 8:00 p.m., however the medication was not administered timely on .*
- *Resident is prescribed instill 1 drop in both eyes two times a day for dry eyes, however the medication was not administered timely on*
- *Resident is prescribed give 1 tablet by mouth at bedtime for constipation, however the medication was not administered timely on*
- *Resident is prescribed apply to L lower leg topically at bedtime for neuropathy, however the medication was not administered timely on .*
- *Resident is prescribed , give 1 tablet by mouth four times a day for chronic pain, however the medication was not administered timely on*

- *Resident is prescribed release 24 hour 90mg give 1 tablet by mouth one time a day for at 8:00 p.m., however the medication was not administered timely on*

- *Resident is prescribed per wound care expert's recommendations. Turn resident to right or left side every 2 hours during the night to relieve the pressure on wound. Use pillows to help turn resident five times a day. However, the order was not followed as per the wound care expert's recommendations on ,*

- *Resident is prescribed give 1 tablet by mouth in the morning for HTN at 8:00 a.m., however the medication was not administered timely on .*

187d - Follow Prescriber's Orders (continued)

- Resident [redacted] is prescribed [redacted] give 1 capsule by mouth in the morning related to bipolar disorder at 8:00 a.m., however the medication was not administered timely on [redacted]

Plan of Correction ***Accept [redacted] - 10/09/2025)***

-9/9/25 - Administrator verbally educated all staff present the importance of following the Prescriber's orders exactly as they are written when providing care for or administering medications to the residents with specific emphasis on timely administration of prescribed medications.
-10/2/25 and 10/3/25 - The administrator conducted an in-service for all LPN's, Med Tech's and Nurse Assistants to emphasize the importance in following prescriber's directions exactly regarding resident care and medications. Documentation of completion of training will be kept in accordance with 2600.65i
-9/11/25 –9/26/25- Administrator and LPN's conducted audit of all resident records including prescribed medications, to ensure all MD orders are being followed correctly.
-10/1/25 - Administrator/Designee will audit 10 resident charts monthly including new admissions to ensure all prescriber orders are being followed. Audit will remain ongoing.
-Beginning 10/1/25 - Administrator will privately interview 5 residents weekly for 3 months, including new admissions (until 01/01/26) and 5 residents monthly thereafter, to ensure compliance with 2600.187(d)
-10/8/25 - Administrator notified Resident [redacted], and the prescriber of the medication errors which occurred on 4/8/25. Resident [redacted] said [redacted] would notify [redacted] daughter (POA). Any new direction given by the prescriber related to the medication error will be updated in the medical records and followed. Reportable incident was submitted for Resident [redacted] as a result of complaint survey and discovery of the medication errors per the surveyor and Licensing Inspection Summary. Resident [redacted]'s permanent records were updated by the Administrator to indicate the medication errors.
-10/8/25 - Administrator notified Resident [redacted] their designated person, and the prescriber of the medication errors which occurred on 4/6/25, 4/7/25, 4/8/25, 4/11/25, 8/10/25, 8/12/25, 8/13/25, 8/14/25, 8/15/25, 8/16/25. Any new direction given by the prescriber related to the medication errors will be updated in the medical records and followed. Reportable incident was submitted for Resident 2 as a result of complaint survey and discovery of the medication errors per the surveyor and Licensing Inspection Summary. Resident [redacted] permanent records were updated by the Administrator to indicate the medication errors.
-10/8/25 - Administrator notified Resident [redacted] their designated person, and the prescriber of the medication errors which occurred on 4/6/25, 4/7/25, 4/8/25, 4/9/25, 4/10/25, 4/11/25, 4/12/25, 8/10/25, 8/11/25, 8/12/25, 8/13/25, 8/14/25, 8/15/25, 8/16/25. Any new direction given by the prescriber related to the medication errors will be updated in the medical records and followed. Reportable incident was submitted for Resident 3 as a result of complaint survey and discovery of the medication errors per the surveyor and Licensing Inspection Summary. Resident [redacted] permanent records were updated by the Administrator to indicate the medication errors.
-10/8/25 - Administrator notified Resident [redacted] their designated person, and the prescriber of the medication errors which occurred on 4/11/25, 8/12/25, 8/13/25, 8/14/25, 8/15/25. Any new direction given by the prescriber related to the medication errors will be updated in the medical records and followed. Reportable incident was submitted for Resident [redacted] as a result of complaint survey and discovery of the medication errors per the surveyor and Licensing Inspection Summary. Resident [redacted] permanent records were updated by the Administrator to indicate the medication errors.
-10/8/25 - Administrator notified Resident [redacted] their designated person, and the prescriber of the medication errors

187d - Follow Prescriber's Orders (continued)

which occurred on 4/6/25, 4/7/25, 4/8/25, 4/9/25, 4/10/25, 4/11/25, 4/12/25, 8/10/25, 8/11/25, 8/12/25, 8/13/25, 8/15/25, 8/16/25. Any new direction given by the prescriber related to the medication errors will be updated in the medical records and followed. Reportable incident was submitted for Resident 5 as a result of complaint survey and discovery of the medication errors per the surveyor and Licensing Inspection Summary. Resident [redacted]'s permanent records were updated by the Administrator to indicate the medication errors.

Licensee's Proposed Overall Completion Date: *10/09/2025*

Implemented ([redacted] - 10/15/2025)