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

October 15, 2025

[redacted], OWNER
GRAND AT FAYETTE LLC
[redacted]

RE: GRAND AT FAYETTE D/B/A
COUNTRY CARE MANOR
205 COLDREN ROAD
FAYETTE CITY, PA, 15438
LICENSE/COC#: 44959

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/24/2025 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: *GRAND AT FAYETTE D/B/A COUNTRY CARE MANOR* **License #**: *44959* **License Expiration**: *05/15/2026*

Address: *205 COLDREN ROAD, FAYETTE CITY, PA 15438*

County: *FAYETTE* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *GRAND AT FAYETTE LLC*
Address: [redacted]
Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *09/24/2025* **Issued By**: *Labor & Industry*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *09/24/2025*

Inspection Dates and Department Representative

09/24/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served**: *34*

Secured Dementia Care Unit

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

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *34*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *1*
Have Mobility Need: *18* **Have Physical Disability**: *0*

Inspections / Reviews

09/24/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/12/2025*

10/14/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/15/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/17/2025*

Inspections / Reviews *(continued)*

10/15/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *10/15/2025*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

29a SOPb5i - Hospice Care: Safe Transportation

1. Requirements

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

5. If the provisions of paragraph (4) are initiated, the informed staff person is to immediately practice a fire drill evacuation in accordance with the following:
   i. Access a mode of transport such as a bed on wheels, a chair on wheels or a drag mat in the resident's bedroom or nearby area, which is not currently occupied by the resident.

Description of Violation

During fire drills held from 3/31/25 to 8/22/25, the unknown staff person, who is responsible for evacuating resident #1, did not access and use a mode of transportation that would be safe for the movement of the resident when simulating the evacuation of the resident.

Plan of Correction ***Accept (█ - 10/14/2025)***

Resident #1 was reassessed by OSPTA Hospice on 10/8/2025, and found to not be actively dying. The resident will now be fully evacuated during any future fire drill or actual emergency in accordance with 2600.29. Resident #1's RASP was updated on 10/8/25.

The Administrator or designee will audit the fire drill logs monthly for 6 months to confirm all residents were evacuated from the building and that the evacuation times met the facility's set time frame. Any discrepancies will be immediately addressed through reeducation and corrective action. Results of these audits will be kept by the Administrator.

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

Implemented (█ - 10/15/2025)

29a SOPb5ii - Hospice Care: Fire Drill Simulation

2. Requirements

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

5. If the provisions of paragraph (4) are initiated, the informed staff person is to immediately practice a fire drill evacuation in accordance with the following:
   ii. Reasonably simulate the level of effort required to move the resident and proceed to practice evacuation to the nearest unblocked exit or fire safe area. The simulation will include the number of staff persons that is required during an evacuation to safely move the resident.

Description of Violation

During fire drills held from 3/31/25 to 8/22/25, the required number of staff persons needed to reasonably simulate the level of effort required to move resident #1 and proceed to practice evacuation to the nearest unblocked exit or fire safe area was not practiced.

Plan of Correction ***Accept (█ - 10/14/2025)***

Resident #1 was reassessed by OSPTA Hospice on 10/8/2025, and found to not be actively dying. The resident will now be fully evacuated during any future fire drill or actual emergency in accordance with 2600.29. Resident #1's

29a SOPb5ii - Hospice Care: Fire Drill Simulation (continued)

RASP was updated on 10/8/25.
The Administrator or designee will audit the fire drill logs monthly for 6 months to confirm all residents were evacuated from the building and that the evacuation times met the facility's set time frame. Any discrepancies will be immediately addressed through reeducation and corrective action. Results of these audits will be kept by the Administrator.

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

Implemented (- 10/15/2025)

29a SOPb10 - Hospice Care: Resident Assessment and Support Plan

3. Requirements

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:
10. The resident's assessment and support plan are to be kept current and specify the requirements of this section as it relates to the specific resident.

Description of Violation

Resident 1's assessment and support plan do not address the resident's exclusion from evacuation during fire drills due to status in an active dying process.

Plan of Correction ***Accept (- 10/14/2025)***

Resident #1 was reassessed by Hospice on 10/8/2025, and found to not be actively dying. The resident will now be fully evacuated during any future fire drill or actual emergency in accordance with 2600.29. Resident #1's RASP was updated on 10/8/25.
The Administrator or designee will audit the fire drill logs monthly for 6 months to confirm all residents were evacuated from the building and that the evacuation times met the facility's set time frame. Any discrepancies will be immediately addressed through reeducation and corrective action. Results of these audits will be kept by the Administrator.

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

Implemented (- 10/15/2025)

88a - Surfaces

4. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The fire rated steel exit door located in the basement lower-level next to the living room area would not close all the way without being manually pulled shut.

In the shared resident restroom located in hallway B the white round aluminum ceiling vent and the white square plastic Broan ceiling exhaust fan had white clumps of dust laying on the louvers of the vent, the fan, and matted to the plaster ceiling.

88a - Surfaces (continued)

In the shared resident restroom located in hallway B the nickel-plated light fixture hanging above the sink and mirror had white clumps of dust laying on the glass light fixtures and the metal frame.

In the shared resident restroom located in hallway C marked room #15 the white round aluminum ceiling vent had white clumps of dust laying on the louvers of the vent and matted to the plaster ceiling.

Plan of Correction ***Accept (- 10/14/2025)***

1. Immediate correction to be completed by 10/14/25. The maintenance contractor will repair and adjust the fire-rated steel exit door to ensure it self closes and latches securely without manual assistance. Currently no residents reside on the lower level. The work will include adjustment or replacement of the door closer, hinges, and frame alignment to meet the standards set forth of 2600.88a. Once repaired, the Administrator will verify that the door closes fully and latches automatically. The Administrator or designee will audit all exit doors monthly X 6 to ensure they are self-closing, in good repair, and free of hazards. Results of each audit will be documented on the monthly exit door audit log and reviewed during our annual quality meeting. Results of these audits will be kept by the Administrator.

2, 3, 4 The Housekeeping Manager immediately cleaned and disinfected affected vents, fans, light fixtures, and surrounding plaster ceiling area in the shared resident restroom located in Hallway B and share resident restroom in Hallway C (room #15) on 9/24/25. The Administrator verified the cleanliness and ensured all surfaces mention were clean and free of dust. Housekeeping staff were reeducated on 9/25/25 that included items of 2600.88a. Topics included cleaning and dusting of ceiling vents and exhaust fans. Cleaning of fixtures and metal frames. Inspection of plaster ceilings and surrounding areas for potential dust build up. The Administrator or designee will conduct random audits of restrooms and other areas containing vents, exhaust fans, and light fixtures on a weekly basis X 4 weeks, followed by monthly audit X 6. Results will be documented on the Environmental Cleanliness Audit Log. Any accumulation of dust or debris found during audits will be corrected immediately, and staff involved will receive retraining or corrective action. Audit outcomes and follow-up actions will be kept by the Administrator and reviewed at the annual quality meeting.

Licensee's Proposed Overall Completion Date: *10/14/2025*

Implemented (- 10/15/2025)

103f - Refrigerator/Freezer Temps

5. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

There was no thermometer in the stainless-steel refrigerator/freezer located in the pantry in hallway B.

103f - Refrigerator/Freezer Temps (continued)

Plan of Correction ***Accept (- 10/14/2025)***

Dietary Director replaced the missing thermometer with a new thermometer in the stainless steel refrigerator/freezer immediately on site 9/24/25. The thermometer was verified for accuracy and placed in a visible location for easy temperature checks. The Administrator confirmed that temperatures were within compliance on 9/25/25 and verified the placement. Dietary staff were reeducated on 9/25/25 on topics including: required temperate ranges, how to properly read and document refrigerator/freezer temperatures, and how to report and replace missing or malfunctioning thermometers. The Administrator or designee will audit refrigerators and freezers weekly for four weeks to ensure thermometers are present and functioning. Following that, audits will occur monthly for 2 months. Any missing or inaccurate thermometer will be replaced immediately and retraining of staff will occur. Results of these audits will be kept by the Administrator and reviewed at the annual quality meeting.

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

Implemented (- 10/15/2025)

225a - Assessment 15 Days

6. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #4's medical evaluation, dated includes diagnoses of Cellulitis, DMII neuropathy, hyperlipidemia, coronary artery disease, and vitamin B deficiency; however, these diagnoses are not included on resident #4's assessment, dated Additionally, the medical evaluation orders an assist of 2 wheelchair; however, the assessment includes a moderate mobility assessment requiring moderated physical or oral assistance to evacuate in an emergency.

Resident #5's assessment had the wrong date of admission of however, resident #5's contract was signed and dated

Plan of Correction ***Accept (- 10/14/2025)***

Resident #4's assessment was reviewed and updated on 9/25/25 to ensure all medical diagnoses listed on the Medical Evaluation are now accurately reflected. The mobility section of resident #4's assessment was updated to properly align with assistance of 1 staff member during transfers and at times needs assistance of 2 staff members, and is minimal mobile needing little to no assistance during evacuation. Documentation was reviewed by the Administrator for accuracy and completeness. The Administrator or designee will audit three resident RASP's monthly for 3 months to ensure continued compliance. Any discrepancies found during the audits will be corrected immediately, and trigger staff to be retrained as necessary. RCC and Executive Director received education on 9/26/25. Audit results will be logged and kept by the Administrator and reviewed during the annual quality meeting.

Regarding Resident #5: Per our phone call, this was not a violation. Please remove resident #5 from this citation.

225a - Assessment 15 Days *(continued)*

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

Implemented (- 10/15/2025)

225c - Additional Assessment

7. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #2’s medical evaluation, dated includes diagnoses of retention, angina, and insomnia. However, these diagnoses are not included on resident #2's most recent assessment dated

Resident #3’s medical evaluation, dated includes diagnoses of constipation, overactive bladder, vitamin deficiency, psychiatric disorder, anti-depressant, antipsychotic, muscle spasms, and cholesterol. However, these diagnoses are not included on resident #1’s most recent assessment dated

Plan of Correction ***Accept (- 10/14/2025)***

Resident #2's annual assessment was reviewed and updated to include the diagnoses of retention, angina, and insomnia on 9/26/25. This assessment was reviewed and updated to ensure that all current medical diagnoses listed in the most recent medical evaluation are now accurately reflected on the assessment. The Administrator and Executive Director cross- checked the assessments with resident's medical evaluations to ensure consistency.

Resident #3's annual assessment was reviewed and updated to include the diagnoses of constipation, overactive bladder, vitamin deficiency, psychiatric disorder, depression, antipsychotic use, muscle spasms, and high cholesterol on 9/26/25. This assessment was reviewed and updated to ensure that all current medical diagnoses listed in the most recent medical evaluation are now accurately reflected on the assessment. The Administrator and Executive Director cross- checked the assessments with resident's medical evaluations to ensure consistency.

The Administrator or designee will audit three resident assessments per month for three months to ensure diagnoses from medical evaluations are properly documented on assessments. Any discrepancies identified during audits will be corrected immediately, and staff retrained as necessary.

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

Implemented (- 10/15/2025)