

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

February 6, 2026

[REDACTED]  
SARAH A REED RETIREMENT CENTER  
[REDACTED]

RE: SARAH REED SENIOR LIVING  
227 WEST 22ND STREET  
ERIE, PA, 16502  
LICENSE/COC#: 44761

[REDACTED],  
As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/30/2025 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: SARAH REED SENIOR LIVING License #: 44761 License Expiration: 06/16/2026  
 Address: 227 WEST 22ND STREET, ERIE, PA 16502  
 County: ERIE Region: WESTERN

**Administrator**

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

**Legal Entity**

Name: SARAH A REED RETIREMENT CENTER  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: C-2 LP Date: 10/11/1994 Issued By: Dept. of Labor & Industry

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 92 Waking Staff: 69

**Inspection Information**

Type: Partial Notice: Unannounced BHA Docket #:  
 Reason: Monitoring Exit Conference Date: 09/30/2025

**Inspection Dates and Department Representative**

09/30/2025 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

General Information  
 License Capacity: 100 Residents Served: 73  
 Secured Dementia Care Unit  
 In Home: Yes Area: 1st Floor Capacity: 25 Residents Served: 19  
 Hospice  
 Current Residents: 0  
 Number of Residents Who:  
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 73  
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0  
 Have Mobility Need: 19 Have Physical Disability: 1

**Inspections / Reviews**

09/30/2025 Partial  
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 10/30/2025

11/07/2025 - POC Submission  
 Submitted By: [REDACTED] Date Submitted: 12/16/2025  
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 11/14/2025

Inspections / Reviews *(continued)*

12/12/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/16/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 12/16/2025

02/06/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/16/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

## 42b - Abuse

## 1. Requirements

2600.

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] resident [REDACTED] was admitted to the secure dementia care unit. The resident's assessment, dated [REDACTED], indicates the resident needs prompting/cuing assistance with ambulating and requires no assistance with turning and positioning in bed/chair. Multiple staff interviews indicate resident [REDACTED] was physically active and very ambulatory, regularly walking throughout the home.

On [REDACTED] at approximately 5:40 a.m., staff person A entered resident [REDACTED]'s room and found [REDACTED] laying on the floor, wearing only a brief, and [REDACTED] appeared to be sleeping. Staff person A took the resident's blood pressure and left the room. At approximately 6:00 a.m. staff person A reported to staff person B that resident [REDACTED] was laying on the floor and would not get up. This information was reported to the oncoming shift, and at approximately 7:00 a.m., staff person C asked staff person B for assistance with getting resident [REDACTED] up off the floor. When staff person B and C attempted to move resident [REDACTED] [REDACTED] moaned in pain and staff noticed dried blood on [REDACTED] arm and a [REDACTED] on [REDACTED] left hand and [REDACTED]. It took 4 staff persons to assist resident [REDACTED] off the floor and into a wheelchair. Staff person D took the resident's vitals, treated the resident's [REDACTED] to [REDACTED] with [REDACTED], and gave [REDACTED] a [REDACTED].

Staff assisted resident [REDACTED] with dressing and pushed [REDACTED] in a wheelchair to the dining room for breakfast, during which time staff had to assist [REDACTED] with positioning in the wheelchair several times, as [REDACTED] was sliding down in the chair. Staff indicate the resident was not [REDACTED] and usually has a difficult time sitting still even for meals. Staff took resident [REDACTED] back to [REDACTED] room and laid [REDACTED] down in bed until approximately 2:00 p.m., when staff person C took resident [REDACTED] to get a bath in the whirlpool tub. During the bath, resident [REDACTED] was unable to bear weight, was yelling out in pain when [REDACTED] moved around, and staff observed a large lump on [REDACTED] back that was painful to touch. Staff person C reported this to staff person D, and at approximately 3:00 p.m. resident [REDACTED] was sent to the hospital via ambulance where [REDACTED] was admitted and diagnosed with [REDACTED] and [REDACTED]. On 9/15/25, resident [REDACTED] was discharged to a skilled nursing facility.

Repeat Violation: [REDACTED] et al.

## Plan of Correction

Accept [REDACTED] - 12/12/2025)

On 9/9/25, when the facility received confirmation of resident's injuries from the hospital, PCHA conducted an investigation to determine the circumstances which led to the resident being found on the floor of [REDACTED] apartment. APS and DHS reports were submitted as per regulation. PCHA determined staff member from 9/7/25 night shift failed to alert [REDACTED] supervisor that resident was on the floor. Staff member was terminated on 9/9/25. On 9/30/25, DHS Team arrived to conduct inspection of incident. On 10/16/25 PCHA began to re-educate all personal care staff as to steps to follow if a resident is found on the floor. PCHA will meet with all staff members and obtain signed acknowledgement by 11/15/25. When a resident has experience a fall and has been found on the floor by an aide, the aide will notify the Med Tech or LPN so that resident can be assessed for injuries. In the above instance, resident was assessed by LPN and range of motion was within normal limits and cut to arm only required steri strips. The

42b - Abuse (continued)

resident was combative which required several staff member to assist [redacted] off the floor and into the wheelchair. When a resident has had a fall, the resident will be checked on by PCAs, or Med Tech, or LPN each shift for 72 hours to monitor the resident's condition. If condition has changed, PC Coordinator or designee will obtain new order from PCP of resident for treatment recommendation. When applicable, PC Supervisor will add an update to the current assessment and support plan of resident to reflect new change in care. PCHA will review incidents daily and will check resident's assessment and support plan to ensure change is reflected.

Licensee's Proposed Overall Completion Date: 12/03/2025

Implemented [redacted] - 02/06/2026)

81b - Resident Personal Equipment

2. Requirements

2600.

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

The enabler bar attached to resident [redacted] bed was uncovered, exposing 9 areas approximately 18" high between the mattress and the top rail support and approximately 5" wide between the rail supports, posing a potential entrapment hazard.

Plan of Correction

Accept [redacted] - 12/12/2025)

On 9/30/25, the rail was immediately removed from the bed by PC Nurse Manager and responsible party was contacted by PCHA on 10/8/25 to remind [redacted] that a rail of that nature does not meet PA DHS regulations. Responsible party was unaware who had installed the bar and agreed with its removal. Beginning on 11/3/25 through 4/23/2026. PCHA will conduct monthly inspections of all personal care apartments to ensure that all devices and apparatus' are free from hazards and are in good repair.

Licensee's Proposed Overall Completion Date: 12/03/2025

Implemented [redacted] - 02/06/2026)

132h - Designated Meeting Place

3. Requirements

2600.

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on [redacted] at 8:32 a.m., 26 residents out of 78 residents evacuated to a designated meeting place away from the building or within the fire-safe area.

During the fire drill on [redacted] at 2:23 p.m., 15 residents out of 88 residents evacuated to a designated meeting place away from the building or within the fire-safe area.

During the fire drill on [redacted] at 4:30 a.m., 0 residents out of 108 residents evacuated to a designated meeting place away from the building or within the fire-safe area.

132h Designated Meeting Place (continued)

Plan of Correction

Accept [REDACTED] - 12/12/2025)

On 9/30/2025, Maintenance Director spoke with DHS Inspection Team and Team re explained the regulation and the manner in which the report should be structured. On 10/7/2025, PCHA met with Maintenance Director and discussed the expectation of the regulation, again. Maintenance Director will schedule a monthly fire drill and will send the completed fire drill report to PCHA the day following the fire drill so that PCHA can ensure the drill was completed accurately, meeting regulatory requirements. If drill is inaccurate, PCHA will instruct Maintenance Director to conduct another drill prior to the end of each month and drill results will, again, be reviewed by PCHA to ensure drill results are accurate and correct. On 10/21/2025, fire drill was conducted and regulations were met. See attached.

Licensee's Proposed Overall Completion Date: 12/03/2025

Implemented [REDACTED] - 02/06/2026)

142a - Secure Medical Care

4. Requirements

2600.

142.a. The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

Description of Violation

On [REDACTED], resident [REDACTED] was admitted to the secure dementia care unit. The resident's assessment, dated [REDACTED] indicates the resident needs prompting/cuing assistance with [REDACTED] and requires no assistance with turning and positioning in bed/chair. Multiple staff interviews indicate resident [REDACTED] was physically active and very ambulatory, regularly walking throughout the home.

On [REDACTED] at approximately 5:40 a.m., staff person A entered resident [REDACTED] room and found [REDACTED] laying on the floor, wearing only a brief, and [REDACTED] appeared to be sleeping. Staff person A took the resident's blood pressure and left the room. At approximately 6:00 a.m. staff person A reported to staff person B that resident [REDACTED] was laying on the floor and would not get up. This information was reported to the oncoming shift, and at approximately 7:00 a.m., staff person C asked staff person B for assistance with getting resident [REDACTED] up off the floor. When staff person B and C attempted to move resident [REDACTED] [REDACTED] moaned in pain and staff noticed dried blood on [REDACTED] arm and a skin tear on [REDACTED] left hand and forearm. It took 4 staff persons to assist resident [REDACTED] off the floor and into a wheelchair. Staff person D took the resident's vitals, treated the resident's [REDACTED] to [REDACTED] with [REDACTED], and gave [REDACTED] a [REDACTED]

Staff assisted resident [REDACTED] with dressing and pushed [REDACTED] in a wheelchair to the dining room for breakfast, during which time staff had to assist [REDACTED] with positioning in the wheelchair several times, as [REDACTED] was sliding down in the chair. Staff indicate the resident was not [REDACTED] and usually has a difficult time sitting still even for meals. Staff took resident [REDACTED] back to [REDACTED] room and laid [REDACTED] down in bed until approximately 2:00 p.m., when staff person C took resident [REDACTED] to get a bath in the whirlpool tub. During the bath, resident [REDACTED] was unable to bear weight, was yelling out in pain when [REDACTED] moved around, and staff observed a large lump on [REDACTED] back that was painful to touch. Staff person C reported this to staff person D, and at approximately 3:00 p.m. resident [REDACTED] was sent to the hospital via ambulance where [REDACTED] was admitted and diagnosed with [REDACTED] and [REDACTED]. On [REDACTED] resident [REDACTED] was discharged to a skilled nursing facility.

## 142a - Secure Medical Care (continued)

**Plan of Correction**

Accept [REDACTED] 12/12/2025)

On 9/9/25, when the facility received confirmation of resident's injuries from the hospital, PCHA conducted an investigation to determine the circumstances which led to the resident being found on the floor of [REDACTED] apartment. APS and DHS reports were submitted as per regulation. PCHA determined staff member from 9/7/25 night shift failed to alert [REDACTED] supervisor that resident was on the floor. Staff member was terminated on 9/9/25. On 9/30/25, DHS Team arrived to conduct inspection of incident. On 10/16/25 PCHA began to re-educate all personal care staff as to steps to follow if a resident is found on the floor. PCHA will meet with all staff members and obtain signed acknowledgement by 11/15/25. When a resident has experienced a fall and has been found on the floor by an aide, the aide will notify the Med Tech or LPN so that resident can be assessed for injuries. In the above instance, resident was assessed by LPN and range of motion was within normal limits and cut to arm only required steri strips. The resident was combative which required several staff members to assist [REDACTED] off the floor and into the wheelchair. When a resident has had a fall, the resident will be checked on by PCAs, or Med Tech, or LPN each shift for 72 hours to monitor the resident's condition. If condition has changed, PC Coordinator or designee will obtain new order from PCP of resident for treatment recommendation. When applicable, PC Supervisor will add an update to the current assessment and support plan of resident to reflect new change in care. PCHA will review incidents daily and will check resident's assessment and support plan to ensure change is reflected.

Licensee's Proposed Overall Completion Date: 12/04/2025

Implemented [REDACTED] - 02/06/2026)

## 181c - Self-administration Assessment

**5. Requirements**

2600.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(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**

At 10:30 a.m., resident [REDACTED] had a tube of [REDACTED] and a container of [REDACTED] [REDACTED] next to the sink in [REDACTED] bathroom; however, the resident has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

**Plan of Correction**

Accept [REDACTED] - 12/12/2025)

On 9/30/2025, both creams were removed from resident [REDACTED] apartment by PC Nurse Manager and destroyed. Beginning 11/3/2025, PCHA will conduct monthly inspections of personal care apartments to check personal equipment, to ensure there is an existing order for any medication, creams, etc that are in the apartment, and to ensure there is an existing order for the resident to self-administer any medications, creams, etc that are in the apartment. On 10/8/2025, SRSL Home Rules were changed by PCHA to state that residents must have an existing order to self-administer medications, creams, etc before these items are brought into the apartment. On 10/31/2025, PCHA will send out a One Call Now message to all residents and contacts to alert them that these inspections will commence on 11/3/2025 and to state the expectation of bringing in medications, creams, etc for residents. The apartment inspections will be conducted monthly through 4/30/2026.

181c - Self-administration Assessment (continued)

Licensee's Proposed Overall Completion Date: 12/03/2025

Implemented (████ - 02/06/2026)

183b - Meds and Syringes Locked

6. Requirements

2600.

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

At 10:30 a.m., a tube of █████ and a container of █████ were unlocked, unattended, and accessible next to the sink in resident █████ bathroom.

Plan of Correction

Accepted (████ - 12/12/2025)

On 9/30/2025, both creams were removed from resident █████ apartment by PC Nurse Manager and destroyed. Beginning 11/3/2025, PCHA will conduct monthly inspections of personal care apartments to check personal equipment, to ensure there is an existing order for any medication, creams, etc that are in the apartment, and to ensure there is an existing order for the resident to self administer any medications, creams, etc that are in the apartment. On 10/8/2025, SRSL Home Rules were changed by PCHA to state that residents must have an existing order to self administer medications, creams, etc before these items are brought into the apartment. On 10/31/2025, PCHA will send out a One Call Now message to all residents and contacts to alert them that these inspections will commence on 11/3/2025 and to state the expectation of bringing in medications, creams, etc for residents. The apartment inspections will be conducted monthly through 4/30/2026.

Licensee's Proposed Overall Completion Date: 12/03/2025

Implemented (████ - 02/06/2026)

183d - Prescription Current

7. Requirements

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

At 10:30 a.m., there was a tube of █████ next to the sink in resident █████'s bathroom; however, the medication was discontinued on █████.

At 10:30 a.m., there was a container of █████ next to the sink in resident █████ bathroom; however, the medication was discontinued on █████.

Plan of Correction

Accepted (████ - 12/12/2025)

On 9/30/2025, both creams were removed from resident █████ apartment by PC Nurse Manager and destroyed. Beginning 11/3/2025, PCHA will conduct inspections of personal care apartments to check personal equipment, to ensure there is an existing order for any medication, creams, etc that are in the apartment, and to ensure there is an existing order for the resident to self administer any medications, creams, etc that are in the apartment. On 10/8/2025, SRSL Home Rules were changed by PCHA to state that residents must have an existing order to self

**183d - Prescription Current (continued)**

*administer medications, creams, etc before these items are brought into the apartment. On 10/31/2025, PCHA will send out a One Call Now message to all residents and contacts to alert them that these inspections will commence on 11/3/2025 and to state the expectation of bringing in medications, creams, etc for residents. The apartment inspections will be conducted monthly through 4/30/2026.*

**Licensee's Proposed Overall Completion Date: 12/03/2025**

**Implemented [REDACTED] - 02/06/2026)**