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

December 2, 2025

[redacted]
WELLTOWER OPCO GROUP LLC
[redacted]
ATTN LICENSING
[redacted]

RE: HEMSLEY HOUSE PERSONAL &
MEMORY CARE OF UPPER ST. CLAIR
500 VILLAGE DRIVE
UPPER ST. CLAIR, PA, 15241
LICENSE/COC#: 44882

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/23/2025 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: *HEMSLEY HOUSE PERSONAL & MEMORY CARE OF UPPER ST. CLAIR* **License #**: *44882* **License Expiration**: *12/15/2025*

Address: *500 VILLAGE DRIVE, UPPER ST. CLAIR, PA 15241*

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

Administrator

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

Legal Entity

Name: *WELLTOWER OPCO GROUP LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *07/07/2015* **Issued By**: *Twp of Upper St. Clair*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *84* **Waking Staff**: *63*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *10/23/2025*

Inspection Dates and Department Representative

10/23/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *94* **Residents Served**: *56*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *3rd Fl* **Capacity**: *36* **Residents Served**: *21*

Hospice

Current Residents: *19*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *56*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *28* **Have Physical Disability**: *0*

Inspections / Reviews

10/23/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/08/2025*

11/06/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/01/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/12/2025*

Inspections / Reviews *(continued)*

11/12/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *12/01/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *12/03/2025*

12/02/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *12/01/2025*

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

85a Sanitary Conditions

1. Requirements

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

Description of Violation

On [redacted] at approximately 09:41 a.m., there was a large black colored plastic bag sitting on the red carpeting in the hallway next to the emergency exit door of stairwell C that was untied and unsecured. The plastic bag had a pungent odor of urine and was filled with green colored diapers, used folded up incontinent pads and various other used products.

On [redacted] at approximately 10:03 a.m., on the 2nd floor in stairwell C the red carpeted hallway steps had what appeared to be a used white crumpled up tissue lying on the steps, white paper scraps laying in several different areas of the hallway and steps, a used clear latex glove discarded and lying in the hallway leading up to the 3rd floor steps in stairwell C, dried crumpled leaves, along with white plaster chunks strewn about and smashed into the red carpeted steps and hallway.

Plan of Correction ***Directed [redacted] - 11/12/2025)***

• On 10/23/2025 immediate action was taken by the Maintenance Director to remove and discard the large black plastic bag sitting in the hallway.
• On 10/23/2025 action was taken by the Executive Director to place signage in each rear hallway indicating staff not to leave any items in the Hallways. (See Exhibit 1A)
• On 10/23/2025 immediate action was taken by the Maintenance Director to clear all listed debris from stairwell C.
• On 10/23/2025 action was taken by the Executive Director to audit all stairwells for resident trash, belongs, debris, and leaves. Documentation of audit to be kept (see Exhibit 1B)
• On 10/29/25 an Education was provided by the Residence Director to all staff in compliance with regulation 2600.85.a and the need to meet all standard sanitary conditions at all times in the community. Documentation of education to be kept. (See Exhibit 1C)
• Starting on 10/29/2025 the Executive Director, Maintenance Director or designee will audit all Stairwells for cleanliness in coordination with regulation 2600.85.a. 4 times weekly for 4 weeks followed by 2 times weekly for 4 weeks followed by 1 time weekly for 4 weeks. Documentation of Audit to be kept (See Exhibit 1D)
• Results of the audit will be discussed during monthly QMPI meetings starting 2/12/26, The QMPI committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Proposed Overall Completion Date: 12/17/2025

DIRECTED
Within 20 days of receipt of the plan of correction: The administrator shall ensure all aspects of the plan of correction have been initiated. [redacted] 11/12/25

Directed Completion Date: *12/02/2025*

Implemented [redacted] - 12/02/2025)

88a Surfaces

2. 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

On [redacted] at approximately 09:41 a.m., in the stairwell on the 1st floor the hallway leading to the outside parking lot the red carpet was littered with chunks of plaster, tree leaves, paper scraps and string strewn about the carpeting.

On [redacted] at approximately 09:41 a.m., in the stairwell on the 1st floor the tan colored metal emergency exit door that leads to the outside parking lot had an approximate 1" inch piece of gold colored weather stripping pulled away from the lower left side of the door jamb. The weather strip had broken away from and was unsecured due to excessive rust and corrosion caused by water damage to the metal door and metal jamb. As a result, the metal strip was sharp and jagged on the end causing a hazard to all foot traffic that utilized that door.

On [redacted] at approximately 10:05 a.m., on the 2nd floor in stairwell C there was approximately an 8" inch x 2" inch hole in the drywall plaster caused by no door stop and the gold-colored door handle of the metal emergency exit door smashing into the wall causing loose plaster chunks to fall out of the hole and onto the red carpet.

On [redacted] at approximately 10:05 a.m., there were 2 black bed rail side supports approximately 6' foot x 2' foot stacked together and leaning against the wall in the hallway landing in stairwell C along with 2 black support poles approximately 6' feet long also leaning up in the corner next to the sprinkler pipe.

On [redacted] at approximately 9:52 a.m., the exit door in the enclosed porch area also known as the "smoking room" was unable to close and latch securely on its own without having to physically pull it shut.

On [redacted] at approximately 9:55 a.m., the metal push bar on the emergency exit door on the 2nd floor in stairwell A was unable to close and latch securely on its own without having to physically pull it shut.

Plan of Correction ***Directed [redacted] - 11/12/2025)***

• On 10/23/2025 immediate action was taken by the Maintenance Director to clear and remove all listed items and debris from the stairwell on the 1st floor and stairwell C.
• On 10/24/2025 action was taken by our Maintenance Director to temporarily patch and repair the broken weather stripping until a new door could be procured.
• On 10/23/2025 immediate action was taken by our Assistant Maintenance Director to replace the doorstop for the door leading into stairwell C and repair the hole in the drywall caused by the handle. (See Exhibit 2A)
• On 10/23/25 action was taken by Maintenance Director to adjust the Latch on the "Smoking Room" door to improve reliability.
• On 10/23/2025 action was taken by Maintenance Director to adjust the push bar on the 2nd floor emergency exit to insure consistent and proper secure latching of the mechanism.
• On 10/23/25 action was taken by the Executive Director to audit all stairwells and back hallways for compliance with regulation 2600.88.a. "Halls to be free of items and debris. Door stops in place walls in good condition. All doors, push bars, and latches operating properly and in good repair. Documentation of audit to be kept. (See Exhibit 2B)
• On 10/29/25 an Education was provided by the Residence Director to all staff in compliance with regulation 2600.88.a in keeping the community free of hazards. Documentation of education to be kept. (See Exhibit 1C)
• Starting on 10/29/2025 the Executive Director, Maintenance Director, or Designee shall audit all stairwells, hallways, emergency doors and exit doors to ensure proper working order, hazard free conditions, and cleanliness in compliance with regulation 2600.88.a 4 times weekly for 4 weeks followed by 2 times weekly for 4 weeks followed

88a Surfaces (continued)

by 1 time weekly for 4 weeks. Documentation of Audit to be kept (See Exhibit 2C)
• Results of the audit will be discussed during monthly QMPI meetings starting 2/12/26, The QMPI committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Proposed Overall Completion Date: 12/17/2025

DIRECTED
Within 20 days of receipt of the plan of correction: The administrator shall ensure all aspects of the plan of correction have been initiated. [redacted] 11/12/25

Directed Completion Date: *12/02/2025*

Implemented [redacted] 12/02/2025)

100a - Exterior - Free of Hazards

3. Requirements

2600.
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 [redacted] at approximately 9:52 a.m., the front porch located off the bistro area, had a large black rubber hose that was approximately 50' in length coiled up and lying on the concrete porch deck just outside the exit door in an approximate 2' foot x 4' foot area where the residents must walk to utilize the outside porch deck. There was also a second smaller black hose that was lying on the same concrete porch deck just below the hose bib in the walking path directly to the right of the doorway causing a secondary tripping hazard for residents.

Plan of Correction ***Directed [redacted] - 11/12/2025)***

• On 10/23/25 immediate action was taken by the Maintenance Director to remove both the large black rubber hose and smaller black hose from the pathway. (See Exhibit 3A)
• On 10/23/25 immediate action was taken by the Executive director to check all walking paths and porch entryways for tripping hazards. Documentation of Audit to be Kept (See Exhibit 3B)
• On 10/29/25 an education was provided by the Executive Director to all staff In compliance with regulation 2600.100.a keeping the exterior of the building safe and free from hazards. Documentation of education to be kept. (See Exhibit 1C)
• Starting on 10/29/25 the Executive Director, Maintenance Director or designee will Audit the community for compliance with regulation 2600.100.a that all exterior pathways and entryways, are clear of hazards 4 times weekly for 4 weeks followed by 2 times weekly for 4 weeks followed by 1 time weekly for 4 weeks. Documentation of Audit to be kept. (See Exhibit 3D)
• Results of the audit will be discussed during monthly QMPI meetings starting 2/12/26, The QMPI committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Proposed Overall Completion Date: 12/17/2025

100a - Exterior - Free of Hazards (continued)

DIRECTED
Within 20 days of receipt of the plan of correction: The administrator shall ensure all aspects of the plan of correction have been initiated. [redacted] 11/12/25

Directed Completion Date: *12/02/2025*

Implemented [redacted] - 12/02/2025)

109b - Rabies Vaccination

4. Requirements

2600.
109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

On [redacted] at approximately at 09:06 a.m., there were two feral cats were being fed with two mounds of wet cat food and two bowls of dry cat food along with a bowl of water placed on the curb adjacent to the home's maintenance shed in the rear parking lot. Subsequent interviews with staff administration and staff members confirmed that these feral cats were being fed by unknown staff members and employees of the home. The home does not have current certificates of rabies vaccination records for the feral cats that frequent the outside premises of the home.

Plan of Correction ***Directed [redacted] - 11/12/2025)***

• On 10/23/25 Immediate action was taken by the Executive Director to remove all food and water intended for the cats from outside the maintenance shed.
• On 10/23/25 Action was taken by the Executive Director to check the entire premises for food or water that could be intended for feral cats. Documentation of Audit to be Kept. (See Exhibit 4A)
On 10/23/25 action was taken by the Executive Director to audit community pet vaccination records for accuracy in compliance with regulation 2600.100.a (See Exhibit 4A)
• On 10/29/25 an education was provided by the Executive Director to all staff in compliance with regulation 2600.100.a and more specifically the importance of NOT feeding feral cats. Documentation of education to be kept. (See Exhibit 1C)
• On 10/31/25 Cali Cats Rescue was contacted to assist in the removal and adoption of the feral cats from the woods outside the home.
• Starting on 10/29/25 the Executive Director, Maintenance Director or designee will audit the exterior of the community for feral animals and food intended for them as well as audit the pet vaccination records for accuracy 4 times weekly for 4 weeks followed by 2 times weekly for 4 weeks followed by 1 time weekly for 4 weeks. Documentation of Audit to be Kept (See Exhibit 4B)
• Results of the audit will be discussed during monthly QMPI meetings starting 2/12/26, The QMPI committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Proposed Overall Completion Date: 12/17/2025

DIRECTED
Within 20 days of receipt of the plan of correction: The administrator shall ensure all aspects of the plan of correction have been initiated [redacted] 11/12/25

Directed Completion Date: *12/02/2025*

109b - Rabies Vaccination *(continued)*

Implemented [redacted] - 12/02/2025)