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

January 22, 2026

[redacted]
ERIE OPS LLC
[redacted]
SUITE #610
[redacted]

RE: WESTLAKE WOODS AL
3302 WEST LAKE ROAD
ERIE, PA, 16505
LICENSE/COC#: 45407

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/06/2025, 11/07/2025 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: *WESTLAKE WOODS AL* **License #**: *45407* **License Expiration**: *10/31/2025*

Address: *3302 WEST LAKE ROAD, ERIE, PA 16505*

County: *ERIE* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *ERIE OPS LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/31/1997* **Issued By**: *Dept L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *81* **Waking Staff**: *61*

Inspection Information

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

Reason: *Complaint, Provisional* **Exit Conference Date**: *11/07/2025*

Inspection Dates and Department Representative

11/06/2025 - On-Site [redacted]

11/07/2025 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *79* **Residents Served**: *61*

Special Care Unit

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

Hospice

Current Residents:

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *42*

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

Have Mobility Need: *20* **Have Physical Disability**: *1*

Inspections / Reviews

11/06/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/05/2025*

12/10/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/15/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/15/2025*

Inspections / Reviews *(continued)*

12/11/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *01/15/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *01/15/2026*

01/22/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *01/15/2026*

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

51 Criminal background checks

1. Requirements

2800.
51. Criminal background checks
   a. Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).
   b. The hiring policies shall be in accordance with the Department of Aging's Older Adult Protective Services Act policy as posted on the Department of Aging's web site.

Description of Violation

On [redacted] staff person A was hired on [redacted] however, a criminal background check was not completed until [redacted].

Plan of Correction ***Accept [redacted] - 12/10/2025)***

Immediate: Team member's Criminal background check was completed prior to the team member providing any direct care or having contact with residents. The Community maintains the stance that this citation is inaccurate per the AL Regulations and would like for consideration to be removed.
Corrective Actions: Team member's CBC on file on 11/7/25.
Ongoing- All CBC's are current and up to date for new hires. The executive director or designee will complete ongoing audits of 10% of new staff hired staff weekly for four consecutive weeks or until compliance is achieved. Results of audits and corrective actions will be documented and reviewed monthly during Quality Assurance and Improvement Committee meetings by the ED?to support ongoing compliance by 12/5/25.
Overall Completion date 12/29/25

Licensee's Proposed Overall Completion Date: *12/29/2025*

Implemented [redacted] - 01/22/2026)

54a Direct care staff quals

2. Requirements

2800.
54.a. Direct care staff persons shall have the following qualifications:
   1. Be 18 years of age or older, except as permitted in subsection (b).
   2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
   3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.
   4. Be able to communicate in a mode or manner understood by the resident. Strategies that promote interactive communication on the part of direct care staff and individual residents shall be developed in accordance with the resident's final support plan under § 2800.227(e) (relating to development of the final support plan).

Description of Violation

On [redacted], staff person B, hired [redacted], did not have a high school diploma, GED diploma, or active registration status on the Pennsylvania nurse aide registry.
REPEAT VIOLATION:[redacted] et al, [redacted]

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

Immediate: Team member was terminated on [redacted]. Team member did not perform and direct care with residents.
Corrective Actions: Starting on 12/1/2025, the Executive Director or designee will audit 10% of the employee files

54a Direct care staff quals (continued)

to verify they have a high school diploma, GED, or current Nurse aide registry. Training done with hiring managers on 12/10/25.
Ongoing: The Executive Director or designee will complete Ongoing audits of 10% of new staff hired for four consecutive weeks or until compliance is achieved. Audits will occur monthly after compliance. Results of audits and corrective actions will be documented and reviewed monthly during Quality Assurance and Improvement Committee meetings by the ED to support ongoing compliance by 12/5/25
Overall Completion date: 12/29/25

Licensee's Proposed Overall Completion Date: *12/29/2025*

Implemented [redacted] - 01/22/2026)

81b Resident equip – good repair

3. Requirements

2800.
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

On [redacted], the bed enabler on resident [redacted] bed was not secured, leaving the enabler to shift 2 3 inches side to side and 3 4 inch shift from the mattress; posing an entrapment hazard and a fall risk.

On [redacted] the bed enabler on resident [redacted]s bed was not secured, leaving the enabler to shift 2 3 inches side to side; posing an entrapment hazard and a fall risk.

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

Corrective action was taken immediately. The bed enablers for residents [redacted] and [redacted] were secured to prevent hazard and fall risks.
To prevent recurrence, the Health and Wellness Director implemented a process for quarterly audits starting on 12/8/25 of all resident equipment to ensure that items remain free of hazards, properly fitted, and in good repair.
Direct care staff were re educated on 12/4/25 regarding the requirement to promptly report any damaged or potentially unsafe equipment so that corrective action can be taken immediately.
Ongoing monitoring will occur through monthly Quality Assurance meetings, where equipment audit findings will be reviewed to identify trends and ensure compliance is sustained by 12/5/25.
Overall completion date 12/29/25

Licensee's Proposed Overall Completion Date: *12/29/2025*

Implemented [redacted] - 01/22/2026)

103g Storing food

4. Requirements

2800.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On [redacted], 14 frozen hamburger patties in the walk in cooler, were opened and not sealed.

103g Storing food (continued)

On [redacted] a bag of bacon, in a box, in the walk-in cooler, was opened and not sealed.

On [redacted], two 20 lb bags containing dried green split peas in the dry storage area were opened and not sealed.

Plan of Correction ***Accept [redacted] - 12/10/2025)***

Corrective action was taken immediately as the bags were properly sealed and stored. On 12/3/25 all culinary staff were re-educated on the requirement that all food must be kept in closed or sealed containers at all times to prevent contamination.
To prevent recurrence, Starting on 12/1/25, the Culinary Services Director implemented daily visual checks of dry storage areas to ensure all items remain properly sealed. Results will be documented and reviewed weekly by the Executive Director for the next 60 days, then monthly thereafter. Any noncompliance will result in immediate corrective action.
All corrective actions will be completed by 12/29/25, with the Culinary Services Director and Executive Director responsible for sustained compliance.

Licensee's Proposed Overall Completion Date: *12/29/2025*

Implemented [redacted] 01/22/2026)

181c Self-Administer Assessment

5. Requirements

2800.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2800.227(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

On [redacted] a tube of [redacted]% was unlocked and accessible in the bathroom in resident [redacted] living unit. Resident interviews indicated this resident was self-administering this medication; however, the medical evaluation, completed [redacted], indicated this resident is unable to self-administer medication nor did it indicate the residents ability to keep this medication at bedside.

Plan of Correction ***Accept [redacted] 12/10/2025)***

Resident [redacted]s assessment and support plan were reviewed on 12/01/25. The Health and Wellness Director reviewed the resident's medical record and ensured the most updated information was incorporated into the assessment and support plan.
Both assessment and service plan reflect the inability to self-administer medications as outlined by [redacted] medical provider.
To prevent recurrence, the HWD will educate Team members on the provider's order for the ability or inability to self-administer medication. Educate staff to review support plans, observe and report any medications that are discovered in a Resident apartment that is not capable of self- administration to seek guidance or clarification. Education with staff will be initiated by 12/18/2025.
The Health and Wellness Director or Designee will review all external medical evaluations within 48 hours of receipt and document any necessary updates to assessments and support plans.
Ongoing monitoring will occur through monthly chart audits completed by the Health and Wellness Director, with results reported at the Quality Assurance meeting. Any discrepancies between medical evaluations and

181c Self Administer Assessment (continued)

assessments will be immediately corrected.
All corrective actions will be fully implemented by 12/29/25, with the Health and Wellness Director responsible for oversight and sustained compliance.

Licensee's Proposed Overall Completion Date: *12/29/2025*

Implemented [redacted] - 01/22/2026)

183b Medications and syringes locked

6. Requirements

2800.
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 living unit.

Description of Violation

On [redacted], a tube of [redacted] was unlocked and accessible in the bathroom in resident [redacted] living unit. This resident was not assessed to self administer this medication nor assessed to keep this at bedside.

On [redacted] a tube of [redacted] wound dressing and a medicine cup, labeled with resident [redacted]'s room number, containing a white crème were unlocked and accessible on the bathroom sink in the living unit belonging to resident [redacted]

On [redacted], a medicine cup, containing a white cream was unlocked, unattended, and accessible in the living unit belonging to resident [redacted]

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

The HWD or Designee will educate Med Passers on Resident's unable to self administer are unable to have medications stored or kept in the apartment home. Medications will remain on the medication cart until time of administration. Education will be initiated on 12/4/25.
Starting on 12/8/25, The HWD or Designee will audit 10 % of Resident's apartments of those unable to self administer medications weekly for 4 weeks or until compliance has been achieved.
These audit results will be reviewed during weekly leadership huddles and discussed at the next Quality Assurance meetings, Immediate corrective action will be taken for any deviations identified. Documentation of audits and Quality Assurance meetings will be maintained by 12/5/25.
Overall completion date 12/29/25

Licensee's Proposed Overall Completion Date: *12/29/2025*

Implemented [redacted] - 01/22/2026)

185a Storage procedures

7. Requirements

2800.
185.a. The residence shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On [redacted], resident [redacted] was prescribed [redacted] inject subcutaneously before meal and at bedtime per sliding scale four times daily: 61 200 0U;201 250 3U; 251 300 6U;301 350 9U; 351 400 12U call Md if BS

185a Storage procedures (continued)

<60 or >400. However, the following blood sugar readings present on the glucometer were not recorded on the medication administration record (MAR) for the following dates and times:
Date & Time Glucometer Reading

[redacted]

On [redacted] resident [redacted] was prescribed [redacted], inject subcutaneously before meal and at bedtime per sliding scale four times daily: 61-200=0U;201-250=3U; 251-300=6U;301-350=9U; 351-400=12U call Md if BS <60 or >400. The following blood sugar readings were documented on the residents October 2025 MAR; however, no blood sugar readings were present on resident [redacted]'s glucometer for these dates and times:
Date & Time MAR

[redacted]

On [redacted], resident [redacted] was ordered blood glucose checks four times a day at 08:00, 11:00, 17:00, and 20:00 and glucometer checks weekly on Tuesdays at 14:00. However, the following blood sugar readings present on the glucometer were not recorded on the medication administration record (MAR) for the following dates and times:
Date & Time Glucometer Reading

[redacted]

On [redacted] resident [redacted] was ordered blood glucose checks four times a day at 08:00, 11:00, 17:00, and 20:00 and glucometer checks weekly on Tuesdays at 14:00. The following blood sugar readings were documented on the residents October and November 2025 MAR; however, no blood sugar readings were present on resident [redacted] glucometer for these dates and times:
Date & Time MAR

[redacted]

On [redacted], resident [redacted] was ordered blood glucose checks four times a day before breakfast, before lunch, before dinner, and at bedtime, at 08:00, 12:00, 16:00, and 20:00 and glucometer checks weekly on Tuesdays at 11:00. The following blood sugar readings were documented on the residents October and November 2025 MAR; however, no blood sugar readings were present on resident [redacted] glucometer for these dates and times:
Date & Time MAR

185a Storage procedures (continued)

[redacted]

On [redacted] resident [redacted] was ordered blood glucose checks two times a day at 08:00 and 20:00 and glucometer checks weekly on Wednesdays at 14:00 as well as Weekly BG report- print weekly BG report and compare readings to glucometer(ensure all recorded readings; date, time, BG readings are entered correctly) one time a day every Monday. However, the following blood sugar readings present on the glucometer were not recorded on the medication administration record (MAR) for the following dates and times:
Date & Time Glucometer Reading
[redacted]

On [redacted] resident [redacted] was ordered blood glucose checks two times a day at 08:00 and 20:00 and glucometer checks weekly on Wednesdays at 14:00 as well as Weekly BG report- print weekly BG report and compare readings to glucometer(ensure all recorded readings; date, time, BG readings are entered correctly) one time a day every Monday. The blood sugar reading of [redacted] on [redacted] at 19:52 and all blood sugar readings prior to [redacted] were not present on resident [redacted] glucometer.

On [redacted] resident [redacted] was ordered blood glucose checks before meals and at bedtime for one week, start [redacted] - stop [redacted], at 06:30, 11:00, 16:00, and 21:00. Resident [redacted] glucometer indicated a blood glucose reading of [redacted] on [redacted] at 07:39; however, this reading was not documented on the residents MAR or a Blood Sugar sheet.

On [redacted], resident [redacted] was ordered blood glucose checks before meals and at bedtime for one week, start [redacted] - stop [redacted], at 06:30, 11:00, 16:00, and 21:00. The following blood sugar readings were documented on the residents October and November 2025 MAR; however, no blood sugar readings were present on resident [redacted] glucometer for these dates and times:
Date & Time MAR
[redacted]

Resident [redacted] was ordered blood glucose checks once every 3 days one time a day. Resident [redacted] glucometer indicated a blood glucose reading of [redacted] on [redacted] at 07:57; however, this reading was not documented on the residents MAR or a Blood Sugar sheet.
REPEAT VIOLATION: [redacted] et al, [redacted] et al, [redacted] et al

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

The MAR for Resident #2,4, 6, 7, 8, 9 were reviewed on 11/18/25, and nursing staff involved in care were counseled 11/20/25 to ensure that all glucometer readings and insulin administrations are recorded in real time on the MAR. The Health and Wellness Director conducted a chart audit for all residents requiring blood glucose monitoring to confirm complete documentation on 11/17/25.
To prevent recurrence, all licensed nurses and medication-trained staff were re-educated on 11/20/25 regarding the requirement to document all blood glucose readings and corresponding medication administrations at the time they occur. A revised documentation policy was implemented requiring cross-checks between the glucometer logs and the MAR once per shift. Additionally, glucometer download audits will be performed weekly by the Health and

185a Storage procedures (continued)

Wellness Director or designee to verify that all readings are documented appropriately in the MAR.
Ongoing monitoring will occur through monthly Quality Assurance reviews, where medication administration documentation compliance will be reported and trends addressed. Any future discrepancies will be corrected immediately, with retraining provided as needed.
All corrective actions will be fully implemented by 12/29/25, with the Health and Wellness Director responsible for oversight and sustained compliance.

Licensee's Proposed Overall Completion Date: *12/29/2025*

Implemented (- 01/22/2026)

187b Date/time of med admin

8. Requirements

2800.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

On , at 11:19 a.m. there was a 2.5 ounce tube of wound dressing, and a medicine cup, labeled with resident room number, containing a white crème on the bathroom sink in the private bathroom in the living unit belonging to resident . According to resident interview with resident , staff bring the white cream in and set it on the sink in the morning and another staff comes in later to use on the wound on this residents back. However, the resident's November 2025 medication administration record (MAR) indicates the resident was administered the medication on at 8:00 a.m.

Plan of Correction ***Accept - 12/10/2025)***

The HWD or Designee will provide education to Med Passers regarding documentation at the time of administration by 12/4/25.
Starting on 12/8/25 The HWD or Designee will review documentation and medication observations to determine timely documentation of the administration for 10 % of Residents weekly for 4 consecutive weeks or until compliance has been achieved.
These audit results will be reviewed during weekly leadership huddles and discussed at the next Quality Assurance meeting. Immediate corrective action will be taken for any deviations identified. Documentation of audits and Quality Assurance meetings will be maintained.
Overall completion date 12//29/25

Licensee's Proposed Overall Completion Date: *12/29/2025*

Implemented (- 01/22/2026)