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

January 21, 2026

[redacted]
UPMC SENIOR COMMUNITIES
[redacted]

RE: STRABANE WOODS OF WASHINGTON
319 WELLNESS WAY
WASHINGTON, PA, 15301
LICENSE/COC#: 44542

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/08/2025, 12/09/2025 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: *STRABANE WOODS OF WASHINGTON* **License #**: *44542* **License Expiration**: *01/28/2027*

Address: *319 WELLNESS WAY, WASHINGTON, PA 15301*

County: *WASHINGTON* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *UPMC SENIOR COMMUNITIES*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *11/17/1999* **Issued By**: *South Strabane Twp*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *94* **Waking Staff**: *71*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *12/09/2025*

Inspection Dates and Department Representative

12/08/2025 - On-Site: [redacted]

12/09/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *74*

Special Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *74*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *20* **Have Physical Disability**: *0*

Inspections / Reviews

12/08/2025 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/25/2025*

01/13/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/21/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/16/2026*

Inspections / Reviews *(continued)*

01/15/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *01/21/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *01/21/2026*

01/21/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *01/21/2026*

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

65a Fire Safety-1st day

1. Requirements

2800.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
6. Smoke detectors and fire alarms.

Description of Violation

Direct care staff person A, hired on [redacted], did not receive general orientation in general fire safety and emergency preparedness that included the following:
3. Designated meeting place outside/interior fire safe area.
6. Smoke detectors & fire alarms.

Ancillary staff person B, hired on [redacted], did not receive general orientation in general fire safety and emergency preparedness that included the following:
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.

Plan of Correction ***Accept [redacted] - 01/15/2026)***

2800.65.a. Fire Safety First Day

1. Direct Care Staff person "A" and Ancillary Staff "B" did not receive general orientation in general fire safety and emergency preparedness that included: 3. Designated meeting place outside/interior fire safe area. 6. Smoke detectors and fire alarms.

2. These employees received general orientation in general fire safety and emergency preparedness on 12/12/2025 to satisfy the missed orientation requirements for 2800.26.a.

3. The Administrator educated the Director or Resident Care and the Administrative Assistant, the individuals responsible for maintaining compliance and documentation, on the requirements of 2800.65.a as it relates to this violation. Education was completed on 12/12/2025. Documentation of the education will be maintained in accordance with 2800.65 (l).

4. A new form has been created to better capture completion of orientation requirements for every new hire.

5. The Administrative Assistant will review all new hires in the last 12 months and audit new employees. Paperwork/documentation for completion beginning 3 business days from the acceptance of this Plan of Correction and will continue for 3 months or until substantial compliance is achieved.

Licensee's Proposed Overall Completion Date: *01/14/2026*

Implemented [redacted] - 01/21/2026)

65e Rights/Abuse 40 Hours

2. Requirements

65e Rights/Abuse 40 Hours *(continued)*

2800.

65.e. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102).
4. Reporting of reportable incidents and conditions.
5. Safe management techniques.
6. Core competency training that includes the following:

Description of Violation

Ancillary staff person B, hired on [redacted] worked in excess of forty hours and did not receive orientation that included the following:

1. Resident Rights.

2. Emergency Medical Plan.

3. OPSA Older Adult Protective Services Act.

4. Reportable incidents.

5. Safe management Techniques.

6. Core competency training.

(i) Person-centered care.

(iii) Nutritional support according to resident preference.

Direct care staff person A, hired on [redacted], worked in excess of forty hours and did not receive orientation that included the following:

2. Emergency medical plan.

4. Reporting of reportable incidents and conditions.

5. Safe management techniques.

Plan of Correction ***Accept ([redacted] - 01/15/2026)***

2800.65.e. Rights/Abuse 40 Hours

1. Direct Care Staff person "A" and Ancillary Staff person "B" did not receive required orientation within 40 scheduled working hours.

2. These employees will receive orientation for missed requirements as outlined in 2800.26.e by January 9, 2026. The education will be documented in accordance to 2800.65(l).

3. The Administrator educated the Director or Resident Care and the Administrative Assistant, the individuals responsible for maintaining compliance and documentation, on the requirements of 2800.65.e. Documentation of education will be maintained in accordance with 2800.65 (l).

4. A new form has been created to better capture completion of orientation requirements for every new hire.

5. The Administrative Assistant will review all new hires in the last 12 months and audit new employees. Paperwork/documentation for completion beginning 3 business days from the acceptance of this Plan of Correction and will continue for 3 months or until substantial compliance is achieved.

Licensee's Proposed Overall Completion Date: *01/14/2026*

Implemented [redacted] - 01/21/2026)

65j Annual training content

3. Requirements

2800.
65.j. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

Direct care staff person C, hired on [redacted], did not receive the following topics during the [redacted] staff training year:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Ancillary staff person D, hired on [redacted] did not receive the following topics during the [redacted] staff training year:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Plan of Correction ***Accept ([redacted] - 01/15/2026)***

2800.65.j. Annual Fire Safety Training
1. Direct Care Staff C And Ancillary Staff D did not receive Fire Safety Training by a Fire Safety Expert during the 1/1/2024 to 12/31/2024 Staff Training year.
2. Staff members "C" & "D" have been trained by a Fire Safety Expert on 12/31/2025. Documentation of training will be kept in accordance with 2800.65 (l).
3. Annual building specific fire safety training for all staff has been completed by 12/31/2025 to ensure compliance with the 1/1/2025 to 12/31/2025 Staff Training year.
4. Additionally, Fire Safety Training is scheduled for all staff on 1/28/26 by a Fire Safety Expert. A video of the fire safety training will be made and will be utilized to meet the need of annual fire safety training by a fire safety expert or by a staff person trained by a fire safety expert.
5. The Regional Director will educate the facility Administrator that direct care staff, ancillary staff, substitute personnel and regularly scheduled volunteers shall be trained annually in fire safety by a fire safety expert or by a staff person trained by a fire safety expert. Documentation for completion of the training will be kept in accordance with 2800.65 (l).
6. The Administrator and/or designee will audit all employee 2025 annual training transcripts through December 31, 2025, to ensure that annual Fire Safety training has been offered and completed. Audits will begin within 3 business days of the receipt of an approved plan of correction.
7. Audit findings will be reviewed by the administrator or the designee monthly, within 3 business days upon the acceptance of this POC and will continue for 3 months or until compliance is achieved.

Licensee's Proposed Overall Completion Date: *01/14/2026*

Implemented [redacted] - 01/21/2026)

65l Record of training

4. Requirements

2800.

65l Record of training *(continued)*

65.l. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

Direct care staff person A's, Department Specific Onboarding Checklist did not include the dates of [redacted] training.

Plan of Correction ***Accept[redacted] - 01/15/2026)***

2800.65.l

Direct Care Staff person "A" Department Specific Onboarding Checklist did not include the dates of training.

1. The Administrator educated the Director of Resident Care and the Administrative Assistant, the individuals responsible for maintaining compliance and documentation, on the requirements of 2800.65 (l). as it relates to this violation. Education was completed on 12/12/2025. Documentation of the education will be maintained in accordance with 2800.65 (l).

2. A new form has been created to better capture completion of orientation requirements for every new hire.

3. The Administrative Assistant will audit all new hire paperwork/documentation for completion beginning 3 business days from the acceptance of this Plan of Correction and will continue for 3 months or until substantial compliance is achieved.

Licensee's Proposed Overall Completion Date: *01/14/2026*

Implemented[redacted] - 01/21/2026)

69 Dementia training

5. Requirements

2800.

69. Additional Dementia-Specific Training - Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

Description of Violation

Ancillary staff person B, hired[redacted], received only 3.25 hours of the required 4 hours dementia-specific training within 30 days of being hired.

Plan of Correction ***Accept[redacted] - 01/15/2026)***

2800.69.

Ancillary Staff person "B" hired on 01/06/25, received only 3.25 hours of the required 4 hours of dementia-specific training within 30 days of being hired.

1. The Administrator educated the Director or Resident Care and the Administrative Assistant, the individuals responsible for maintaining compliance and documentation, on the requirements of 2800.69. Education was completed on 12/12/2025. Documentation of the education will be maintained in accordance with 2800.65 (l).

2. A new form has been created to better capture completion of orientation requirements for every new hire.

3. The Administrative Assistant will audit all new hire paperwork/documentation for completion beginning 3 business days from the acceptance of this Plan of Correction and will continue for 3 months or until substantial compliance is achieved.

69 Dementia training (continued)

Licensee's Proposed Overall Completion Date: *01/14/2026*

Implemented [redacted] - 01/21/2026)

88a Floors, walls, ceilings, windows, doors

6. Requirements

2800.
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 12:25 p.m., the emergency exit door located in the 1st floor stairwell leading to the rear courtyard needed significant force to open the door. Once opened the door would not securely close or latch without someone forcefully pushing it shut from the outside.

Plan of Correction ***Accept [redacted] - 01/15/2026)***

2800.88a
1. The Emergency exit door on the first floor near rear courtyard was difficult to open and the door would not securely latch without force.
2. Maintenance has corrected the concern with the opening of the door for egress. Permanent repair and/or replacement of the door will be complete by January 31, 2026.
3. The Maintenance Technician will include monthly checks of all exterior exits. Completion will be documented on the Preventative Maintenance task list effective January 2026 and monthly thereafter.
4. The administrator or designee will randomly check exterior exit doors monthly and document on the Weekly facility report that is submitted to the Regional Director.

Licensee's Proposed Overall Completion Date: *01/14/2026*

Implemented [redacted] - 01/21/2026)

103c Food protected

7. Requirements

2800.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On [redacted] at approximately 12:56 p.m., in the main kitchen areas walk-in fridge, there were two metal trays with approximately 8 round coconut cream pies that were not covered and unprotected from contamination.

Plan of Correction ***Accept [redacted] - 01/15/2026)***

Strabane Woods Dining Services Department
2800.103c
1. Description of Violation On 12/8/25 at approximately 12:56 p.m., in the main kitchen areas walk-in fridge, there were two metal trays with approximately 8 round coconut cream pies that were not covered and unprotected from contamination.
2. Pies were immediately covered upon notification of improper method.

103c Food protected (continued)

3. Dietary Director will conduct education for Dietary manager by January 15, 2026 for the Dietary Director and all cooks. Documentation of training will be kept in accordance with 2800.65 (l).
4. To ensure that all food is properly stored and covered audits will be conducted 2x per day by the manager or chef on duty after meal preparation to monitor proper food storage.
5. These audits will be conducted for two months beginning three business days following acceptance of the Plan of Correction.

Licensee's Proposed Overall Completion Date: *01/14/2026*

Implemented [redacted] - 01/21/2026)

132c Fire drill records

9. Requirements

2800.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the residence at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

On [redacted] the home conducted a fire drill at 2:00 p.m. However, the residence fire drill record indicates the time of the fire drill was 3:00 p.m. and the fire drill record does not include the exit route that was used it only had the word "yes" written in the box provided on the report.

On [redacted], the home conducted a night-time fire drill at 5:30 a.m. The residence fire drill record does not indicate the exit routes used, or the number of residents present during the fire drill.

On [redacted] the home conducted a fire drill at 3:30 p.m. However, the fire drill record did not include the amount of time it took for evacuation, this section was left blank.

Plan of Correction ***Accept ([redacted] - 01/15/2026)***

2800.132.c. Fire Drill Records
1. Documentation in Fire Drill Record was found to be insufficient on 09/30/25, 10/29/25, and 11/6/25.
2. The Administrator will educate the Maintenance Person and Administrative Assistant, the individuals responsible for conducting the fire drills, on the requirements of 2800.132.c. as it relates to this violation on 09/30/25, 10/29/25, and 11/6/25. This will be completed by January 9, 2026. Documentation of the education will be maintained in accordance with 2800.65 (l).
3. The Administrator or designee will audit fire drill records monthly on an ongoing basis to ensure that all required elements are included on the record. The audits will begin within 3 business days of the receipt of an approved plan of correction, and will continue for three months.
4. Audit findings will be reviewed by the Administrator and Regional Director, beginning within 3 business days upon receipt of the acceptance of this plan of correction.

Licensee's Proposed Overall Completion Date: *01/14/2026*

Implemented [redacted] - 01/21/2026)

132d Evacuation

10. Requirements

2800.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the residence.

Description of Violation

Between [redacted] and [redacted] the home did not have a fire-safe area designated in writing within the past year by a fire safety expert and did not have a safe evacuation time specified in writing by a fire safety expert within the past year. This defaults the residences fire safe evacuation time to 2 minutes and 30 seconds.

On [redacted], the home conducted a fire drill at 2:00 p.m. with 75 residents present in the home. However, only 54 residents were evacuated during the fire drill evacuation time was 4 minutes and 52 seconds.

On [redacted] at 5:30 a.m., the residences conducted a fire drill at 5:30 a.m., and the time the alarm was reset was 5:40 a.m., recording the amount of time to evacuate as 10 minutes.

Plan of Correction ***Accept [redacted] 01/15/2026)***

2800.132.d Evacuation
1. The facility did not specify a designated fire safe area nor documentation of safe evacuation time by Fire Safety Expert.
2. Documentation from the South Strabane Township Captain was received 12/31/2025 that specifies fire evacuation time and fire safe area designation. [redacted] was also on site to review evacuation procedures with Administrator and Maintenance Director.
4. A revised Evacuation form will be implemented beginning in January 2026.
5. The Administrator or designee will audit fire drill records and evacuation procedures monthly on an ongoing basis to ensure that all required elements are included on the record. The audits will begin within 3 business days of the receipt of an approved plan of correction.
6. Audit findings will be reviewed by the Administrator and Regional Director, beginning within 3 business days upon receipt of the acceptance of this plan of correction.

Licensee's Proposed Overall Completion Date: *01/14/2026*

Implemented [redacted] - 01/21/2026)

224a1 Initial assessment - RN

11. Requirements

2800.
224.a.1. The administrator, administrator designee, or LPN, under the supervision of an RN, or an RN shall complete the initial assessment.

Description of Violation

The initial assessment for resident [redacted], admitted on [redacted], was not signed or dated and was unable to be determined when it was completed.

224a1 Initial assessment - RN *(continued)*

Plan of Correction ***Accept [redacted] - 01/15/2026)***

2800.224.a1 Initial Assessment
1. The initial assessment for resident [redacted] was not dated by Director of Resident Care.
2. The Administrator will educate the Director of Resident Care regarding the proper completion of Initial Assessments. Education will be completed by January 9, 2026. Documentation of the education will be maintained in accordance with 2800.65 (l).
3. The Director of Resident Care will complete a monthly audit of any new initial assessments to ensure all dates and signatures are completed. Audits will begin within 3 business days of the receipt of an approved plan of correction and continue for three months of compliance.
4. Audit findings will be reviewed by the Administrator and/ or designee monthly, beginning within 3 business days upon receipt of the acceptance of this plan of correction, will continue for 3 months or until substantial compliance is achieved.

Licensee's Proposed Overall Completion Date: *01/14/2026*

Implemented [redacted] - 01/21/2026)

224c1 Initial SP-30 days prior/adm

12. Requirements

2800.
224.c.1. An individual requiring services shall have a written preliminary support plan developed within 30 days prior to admission to the residence unless one of the conditions contained in paragraph (2) applies.

Description of Violation

The preliminary support plan for resident [redacted], admitted on [redacted], was not signed or dated and was unable to be determined when it was completed.

Plan of Correction ***Accept [redacted] - 01/13/2026)***

2800.224.c1 Initial Support Plan
1. The initial Support Plan for resident [redacted] was not signed and dated by Director of Resident Care.
2. The Director of Resident Care signed the Support Plan on September 10, 2025.
3. The Administrator will educate the Director of Resident Care regarding the proper completion of Support Plans to include signatures and dates. Documentation for completion of training will be kept in accordance with 2800.65 (l). Education will be completed by January 9, 2026.
4. The Director of Resident Care will complete a monthly audit of any new initial assessments to ensure signatures are completed. Audits will begin within 3 business days of the receipt of an approved plan of correction and continue for three months of compliance.
5. Audit findings will be reviewed by the Administrator and/ or designee monthly, beginning within 3 business days upon receipt of the acceptance of this plan of correction, will continue for 3 months or until substantial compliance is achieved.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented [redacted] - 01/21/2026)

225b Assessment content

13. Requirements

2800.
225.b. The assessment must, at a minimum include the following:

Description of Violation

Resident [redacted] most recent assessment, dated [redacted], does not include the diagnosis of depression as indicated on the most recent medical evaluation, dated [redacted].

Plan of Correction ***Accept [redacted] - 01/15/2026)***

2800.225.b Assessment Content
1. The annual assessment for resident [redacted] was missing a diagnosis of depression as indicated on 12/5/2025 medical evaluation.
2.The Director of Resident Care and/or designee will audit all annual assessments to ensure medical conditions are include as indicated. At each quarterly review, the support plan will be reviewed by the Director of Resident Care and/or designee to verify that medical conditions are noted as indicated.
3. The Director of Resident Care will educate the Resident Support Coordinator on the need to include medical conditions on the assessments. Documentation for completion of the training will be kept in accordance with 2800.65 (l). Education will be completed by January 9, 2026.
4. The Director of Resident Care and /or designee will complete a monthly audit of 4 assessments to ensure medical conditions are noted as indicated on Medical Evaluations. Audits will begin within 3 business days of the receipt of an approved plan of correction.
5. Audit findings will be reviewed by the Administrator and/ or designee monthly, beginning within 3 business days upon receipt of the acceptance of this plan of correction, will continue for 3 months or until substantial compliance is achieved.

Licensee's Proposed Overall Completion Date: *01/14/2026*

Implemented [redacted] - 01/21/2026)

227g Support plan - signatures

14. Requirements

2800.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

The assessment and support plan for resident [redacted], admitted on [redacted], was not signed or dated by the assessor nor the resident.

Plan of Correction ***Accept [redacted] 01/15/2026)***

2800.227.g Support Plan signatures
1. The initial Support Plan for resident [redacted] was not signed by resident [redacted]
2. The resident signed the Support Plan on December 29, 2025 upon receipt of the Inspection Summary.
3. The Director of Resident Care and/or designee will audit all previously completed Support Plans to ensure assessor and resident signatures are completed.

227g Support plan signatures (continued)

4. Administrator will educate Director of Resident Care on the need to involve the resident with care planning and include signatures on all assessments. Documentation for completion of training will be kept in accordance with 2800.65 (l). Education will be completed by January 9, 2026.
5. The Director of Resident Care will complete a monthly audit of any new initial assessments to ensure signatures are completed. Audits will begin within 3 business days of the receipt of an approved plan of correction.
6. Audit findings will be reviewed by the Administrator and/ or designee monthly, beginning within 3 business days upon receipt of the acceptance of this plan of correction, will continue for 3 months or until substantial compliance is achieved.

Licensee's Proposed Overall Completion Date: *01/14/2026*

Implemented [redacted] - 01/21/2026)