

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

April 21, 2026

[REDACTED]
WRC PENNSYLVANIA MEMORIAL HOME
[REDACTED]

RE: HIGHLAND OAKS AT WATER RUN
300 WATER RUN ROAD
CLARION, PA, 16214
LICENSE/COC#: 44768

[REDACTED],
As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/23/2026 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: *HIGHLAND OAKS AT WATER RUN* License #: *44768* License Expiration: *12/03/2026*
 Address: *300 WATER RUN ROAD, CLARION, PA 16214*
 County: *CLARION* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *WRC PENNSYLVANIA MEMORIAL HOME*
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-2* Date: *05/26/2016* Issued By: *Monroe TWP*
 Type: *I-2* Date: *05/26/2016* Issued By: *Bureau Veritas of North America*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *50* Waking Staff: *38*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Incident* Exit Conference Date: *02/23/2026*

Inspection Dates and Department Representative

02/23/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *72* Residents Served: *49*
 Secured Dementia Care Unit
 In Home: *No* Area: Capacity: Residents Served:
 Hospice
 Current Residents: *0*
 Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *49*
 Diagnosed with Mental Illness: *29* Diagnosed with Intellectual Disability: *29*
 Have Mobility Need: *1* Have Physical Disability: *1*

Inspections / Reviews

02/23/2026 Partial
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/15/2026*

Inspections / Reviews (*continued*)

03/19/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/15/2026

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 03/26/2026

03/24/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/15/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 04/17/2026

04/21/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/15/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

16c - Written Incident Report

1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted] at 2:30 a.m., Resident [redacted] became agitated and aggressive, purposefully ramming [redacted] physical person into the bodies of two separate staff members. Staff members were unable to redirect [redacted] and requested the presence of Independence Emergency Medical Services. Clarion Borough police officers arrived with Independence EMTs who were also unable to redirect resident [redacted]. Clarion Borough police officers, in turn, requested/received Pennsylvania State Police officers' presence at the home for further assistance. However, the home failed to notify the department until [redacted].

Plan of Correction

Accepted [redacted] - 03/24/2026

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth in the Licensing Inspection Summary. The plan of correction is prepared and/or executed to meet the requirement in the provision of federal and state laws and to ensure the health, safety and well-being of our residents is being met.

Highland Oaks at Water Run recognizes and is dedicated to ensuring the health, safety and well-being of our residents.

After this event when EMS was called to assist Highland Oaks staff with Resident [redacted] the Administrator and Wellness Coordinator were notified. EMS arrived on-site with Clarion Borough Police. After attempts to redirect Resident [redacted] the Clarion Borough Police contacted Pennsylvania State Police for direction. PSP then arrived on-site as well. Resident [redacted] adult child was reached by telephone and arrived on-site and Resident [redacted] calmed and went into their room, talked with adult child and fell asleep. All EMS and law enforcement left the facility. The Administrator completed a BHSL Incident Report Form for this incident and upon reviewing the regulations in the Regulatory Compliance Guide Appendix B 2600.16(c)(11) page 233, Homes Do Not Need to Report: Police response to an EMS call for emergency transportation, the report was not submitted.

1. Immediate Action: When speaking with the licensing representative on-site on February 23, 2026, it was clarified that all responses of law enforcement personnel require reporting. The Incident Reporting Form was updated and provided immediately to the licensing representative on February 23, 2026. Person Responsible: Administrator

2. Corrective Action: The report was submitted that day, February 23, 2026, via email to the Northwest Region by Administrator. Person Responsible: Administrator All Staff were educated on Reportable Incidents on March 11, 2026. Person Responsible: Administrator.

3. Preventative Action: All incidents are tracked in a database, and those incidents are marked if they meet the criteria as a Reportable Incident per 55 Pa.Code § 2600.16(c) and an Incident Report is completed and submitted to the Northwest Regional Office. The practice of tracking every incident and reporting of incidents to BHSL to ensure timely reporting will remain with review of the Administrator and Wellness Coordinator. Person Responsible: Administrator and Wellness Coordinator. Incident database was reviewed February 23, 2026.

Licensee's Proposed Overall Completion Date: 03/23/2026

Implemented [redacted] - 04/21/2026

187a - Medication Record

2. Requirements

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident [REDACTED] was prescribed catheter drainage reminder please remind resident to drain catheter three times daily. The resident was administered the treatment on [REDACTED] at 9:00 p.m. However, the treatment's administration was not indicated on the resident's January 2026, Medication Administration Record for the corresponding date and time.

Plan of Correction

Accept [REDACTED] - 03/24/2026)

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth in the Licensing Inspection Summary. The plan of correction is prepared and/or executed to meet the requirement in the provision of federal and state laws and to ensure the health, safety and well-being of our residents is being met.

Highland Oaks at Water Run recognizes and is dedicated to ensuring the health, safety and well-being of our residents.

The electronic medication administration program utilized by Highland Oaks at Water Run is QuickMAR. The QuickMAR system is a computer-based system that syncs with the web-based main system. This enables QuickMAR medication administration to continue in the event there is an outage of internet service. QuickMAR records the administrations and data entered in the software on the individual computer. Once internet connectivity is restored, the data syncs to the main system. It is unclear why the administration of Resident [REDACTED] treatment did not register within the system.

1. Immediate Action: On February 23, 2026, an audit was performed of all other resident medications and treatments administered by that Resident Aide/Medication Technician (RA-MT) that shift and specifically that time. In interviewing the RA-MT on February 23, 2026, [REDACTED] stated that the administration had been completed and entered administration completed and it appeared to save and the system moved on to the next screen as typical. If an administration is not marked completed and saved, and alert window continues to pop-up alerting the staff that a medication or treatment has not been administered/completed. [REDACTED] stated that there no alerts through the remainder of the shift and at the end of the shift. There were no other residents' administrations not recorded. Resident [REDACTED] was the last resident on that hallway requiring administration in that timeframe. Spoke with HOWR's pharmacy representative, and the thought is that the system did not sync with the web-based main system for that resident at that time, which would cause the actual computer to no longer alert as the administration was marked completed, however when the medication administration record was accessed by another user and printed the administrations were not present. Performed February 23, 2026 by Administrator. Person Responsible: Administrator

2. Corrective Action: On February 24, 2026, a paper Medication Administration Record was updated by RA-MT that administered the treatment on January 28, 2026 at 9pm, documenting the administration. This document has been added to Resident [REDACTED]'s medical record. Person(s) Responsible: RA-MT and Administrator.

3. Preventative Action: In an effort mitigate this from occurring again, on February 23, 2026, all computers utilized for QuickMAR administration were checked for QuickMAR software updates and internet connectivity. Staff education to ensure that their User Instance of QuickMAR is synced and uploaded to the web-based program and no alerts of administration remain active after each med pass. Responsible Person(s): Administrator and Wellness Coordinator.

Licensee's Proposed Overall Completion Date: 03/23/2026

Implemented [REDACTED] - 04/21/2026)

225a - Assessment 15 Days

3. 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 [redacted] was admitted on [redacted]. However, the resident's initial assessment was not finalized until [redacted].

Plan of Correction

Accept [redacted] - 03/24/2026)

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth in the Licensing Inspection Summary. The plan of correction is prepared and/or executed to meet the requirement in the provision of federal and state laws and to ensure the health, safety and well-being of our residents is being met.

Highland Oaks at Water Run recognizes and is dedicated to ensuring the health, safety and well-being of our residents.

1. Immediate Action: On February 23, 2026, Resident [redacted]'s Resident Assessment and Support Plan (RASP) dates were reviewed and the completion of the Resident Assessment was finalized two days past the 15 day requirement. Resident [redacted] was admitted on December 22, 2025. The Resident Initial Assessment was immediately started, however, with the Christmas and New Year's holidays and Resident [redacted]'s oldest adult child in from out of state for the holidays, Resident [redacted] was in and out of the facility several times. Resident was seen by [redacted] primary care physician on January 7, 2026 for the Document of Medical Evaluation examination and form completion and the Resident Assessment was able to be completed. This situation was an extenuating circumstance. Person(s) Responsible: Administrator and Wellness Coordinator.

2. Corrective Action: On February 24, 2026, the regulation regarding the RASP was reviewed and re-educated with the Wellness Coordinator. On March 11, 2026, the regulations and requirements of the RASP was re-educated to All Staff. Person Responsible: Administrator.

3. Preventative Action: On February 24, 2026, a full audit of Resident Initial Assessment and annual Resident Assessment and Support Plans (RASP) began to ensure all other initial and annual RASPs were within required timeframes. All RASP dates are recorded within a database upon admission, annually and if there is a significant change, to ensure all are completed within specified timeframes. Person(s) Responsible: Wellness Coordinator and Administrator.

Licensee's Proposed Overall Completion Date: 03/23/2026

Implemented [redacted] - 04/21/2026)

225c - Additional Assessment

4. Requirements

2600.

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

- 2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident [redacted] most recent Assessment and Support Plan completed on [redacted] and [redacted] respectively indicates a personal care need for, bladder management of "direct care staff will remind resident to empty [redacted] catheter bag

225c - Additional Assessment (continued)

several times per day". However, multiple staff members indicate resident [REDACTED] catheter bag was regularly emptied by staff members at bedtime on a daily basis.

Resident [REDACTED] most recent Assessment and Support Plan completed on [REDACTED] and [REDACTED] respectively, indicates a personal care need for, aggression as "no problem / not applicable". However, on [REDACTED] at 2:30 a.m., resident [REDACTED] became agitated and aggressive, purposefully ramming [REDACTED] physical person into the bodies of two separate staff members. Staff members were unable to redirect resident [REDACTED] and requested the presence of Independence Emergency Medical Services. Clarion Borough police officers also arrived with Independence EMTs who were unable to redirect resident [REDACTED]. Clarion Borough police officers, in turn, requested/received Pennsylvania State Police officers' presence at the home for further assistance.

Resident [REDACTED]'s most recent Assessment and Support Plan completed on [REDACTED], and [REDACTED] respectively. Indicates a personal care need for supervision of "Minimal", "Resident does not require supervision in familiar surroundings". However, resident [REDACTED] required staff member redirection on multiple occasions to include but not limited [REDACTED], at 3:38 p.m., [REDACTED], at 7:24 p.m., and [REDACTED] at 9:06 p.m. On [REDACTED] at 8:28 p.m., resident [REDACTED] engaged in amorous activities while in Common Room [REDACTED] with resident [REDACTED] that included prolonged mouth to mouth kissing / contact and resident [REDACTED]'s groping of resident [REDACTED]'s breast causing several fellow residents to complain to staff members about feeling uncomfortable and prompting staff member/s to intervene and redirect the residents.

Plan of Correction**Accept [REDACTED] - 03/24/2026)**

Transfer to a small secure dementia personal care began to be evaluated for Resident [REDACTED] due to the concerns listed on 01/12/2026. Through this process of locating availability of a secure dementia personal care, the staff were aware of the changing needs of Resident [REDACTED]. Admission acceptance in a secure dementia personal care facility was obtained, and Resident [REDACTED] was transferred from Highland Oaks at Water Run on 01/16/2026. During this time as things were moving rapidly towards transfer, the RASP was inadvertently not updated as written in Description of Violation.

Additional clarification on the incident on 1/13/2026 mentioned above actually occurred on 1/15/2026 at 8:45 pm, the Resident Aide-Medication Technician (RA-MT) and Resident Aide (RA) that were standing 15-18 feet away at the nursing base, witnessed this event from when it began and the RA-MT immediately began speaking to the two residents while walking to them and stopped the interaction between the two. Per RA-MT [REDACTED]'s account there was a brief peck kiss, with one hand on the seated Resident [REDACTED]'s shoulder and the other on the side of the neck/jawline. Following the peck kiss they were rubbing foreheads together and laughing as the RA-MT was, within seconds, at their side separating the interlude. RA-MT that witnessed the entire situation chart note is attached. Another RA-MT arrived on the second floor and the scenario stated above was [REDACTED] perspective. This RA-MT entered the 2nd floor off of the elevator approximately 44-46 feet away looking down a long hallway and around pillars and seated residents in the common area. RA-MT [REDACTED] was already at Resident [REDACTED] and Resident [REDACTED]'s side and were separating the residents as RA-MT [REDACTED] exited the elevator and began down the hallway. As RA-MT's description was being told to Administrator during the Exit review, Administrator requested having RA-MT [REDACTED] and RA-MT [REDACTED] come back to clarify what was witnessed. Both RA-MT's returned to the conference area. Licensing Representatives requested RA-MT [REDACTED] first-hand witnessed account of the interaction and then RA-MT [REDACTED]'s perspective. Licensing Representative then stated this was an example of individual perspectives from different locations.

1. Immediate Action: On February 24, 2026, the regulations, requirements and sections of the Resident Assessment and Support Plan (RASP) including Significant Change - Within 5 days of significant change to update the RASP, were re-educated with the Wellness Coordinator and nursing staff and specifically any changes in condition or

225c - Additional Assessment (continued)

significant changes must be communicated to Wellness Coordinator and/or Administrator, and during change of shift reporting real-time. The changes are required to be updated on the RASP within 5 days of occurrence.

Person(s) Responsible: Wellness Coordinator, Administrator, all staff.

2. Corrective Action: On March 11, 2026, All Staff were re-educated on the regulations, requirements and sections of the RASP including Significant Change - Within 5 days of significant change to update the RASP, reporting of changes in condition or significant changes to the Wellness Coordinator and/or Administrator real-time to ensure each resident is receiving the supervision and care they require. The importance of communication of changes in condition or significant change during shift report to ensure the changes are known to the on-coming shifts. Person Responsible: Wellness Coordinator, Administrator and all staff.

3. Preventative Action: On February 24, 2026, all RASPs began being audited to ensure all changes in condition or significant changes have been captured and updated on the current RASP or if new Significant Change RASP is required and completed. Person(s) Responsible: Wellness Coordinator and Administrator.

Licensee's Proposed Overall Completion Date: 04/10/2026

Implemented [REDACTED] - 04/21/2026)