



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to ERIE OPS LLC

LEGAL ENTITY

To operate WESTLAKE WOODS AL

NAME OF FACILITY OR AGENCY

Located at 3302 WEST LAKE ROAD, ERIE, PA 16505

(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide Assisted Living

TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed 79
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

(MAXIMUM CAPACITY)

Restrictions: _____

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2800: Assisted Living Residences

(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from June 10, 2026 until December 10, 2026,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **454073**

Janette Biderup
ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable
and should be posted in a conspicuous place in the facility.

HS 628P – 04/23



Pennsylvania Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: OCTOBER 8, 2026

[REDACTED]
Erie OPS LLC
[REDACTED]
[REDACTED]

RE: Westlake Woods AL
3302 Westlake Road
Erie, Pennsylvania 16505
License/COC #: 454073

[REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on February 27, 2026, March 6, 2026, March 26, 2026, March 27, 2026, April 3, 2026, May 5, 2026, May 6, 2026, August 11, 2026 and August 25, 2026 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), the Department hereby issues you a THIRD PROVISIONAL license to operate the above facility. A THIRD PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4); (5) (relating to conditions for denial, nonrenewal or revocation). Your THIRD PROVISIONAL license is enclosed and is valid from JUNE 10, 2026 to DECEMBER 10, 2026.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a THIRD PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your THIRD PROVISIONAL license, a written request for an appeal must be received within 30 days of the date of this letter by:

Lestia Fetzer, Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
[REDACTED]

This decision is final 31 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,



Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

Cc: [REDACTED]

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

Facility Information

Name: WESTLAKE WOODS AL **License #:** 45407 **License Expiration:** 06/10/2026
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. of Labor & Industry

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 70 **Waking Staff:** 53

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Incident **Exit Conference Date:** 03/06/2026

Inspection Dates and Department Representative

02/27/2026 On Site: [REDACTED]
03/06/2026 On Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 79 **Residents Served:** 49

Special Care Unit

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

Hospice

Current Residents: 1

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 49
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 21 **Have Physical Disability:** 2

Inspections / Reviews

02/27/2026 - Partial

Lead Inspector: [REDACTED] **Follow Up Type:** POC Submission **Follow Up Date:** 04/03/2026

04/28/2026 POC Submission

Submitted By: [REDACTED] Date Submitted: 05/06/2026

Reviewer: [REDACTED] Follow Up Type: Document Submission Follow Up Date: 05/06/2026

09/23/2026 Document Submission

Submitted By: [REDACTED] Date Submitted: 05/06/2026

Reviewer: [REDACTED] Follow Up Type: Enforcement

23a ADL assistance

1. Requirements

2800.

23.a. A residence shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident [REDACTED]'s assessment and support plan, dated [REDACTED], indicates the resident requires a two person transfer with a Hoyer lift and requires assistance with toileting. However, resident [REDACTED] indicates [REDACTED] has waited very long periods of time to receive assistance from staff and, at times, is assisted with transfers using the Hoyer lift with only one staff person.

Resident [REDACTED]'s call bell report indicates the resident did not receive assistance as required on numerous dates to include:

On [REDACTED] at 11:55a.m. resident [REDACTED] pushed [REDACTED] call bell and waited 36 minutes for staff to answer and provide care. On

[REDACTED] at 2:08p.m. resident [REDACTED] pushed [REDACTED] call bell and waited 41 minutes for staff to answer and provide care. On

[REDACTED] at 7:52a.m. resident [REDACTED] pushed [REDACTED] call bell and waited 32 minutes for staff to answer and provide care. On

[REDACTED] at 4:08p.m. resident [REDACTED] pushed [REDACTED] call bell and waited 1 hour 5 minutes for staff to answer and provide care.

On [REDACTED] at 7:27p.m. resident [REDACTED] pushed [REDACTED] call bell and waited 30 minutes for staff to answer and provide care. On

[REDACTED] at 9:51p.m. resident [REDACTED] pushed [REDACTED] call bell and waited 41 minutes for staff to answer and provide care. On

[REDACTED] at 12:54p.m. resident [REDACTED] pushed [REDACTED] call bell and waited 33 minutes for staff to answer and provide care. On

[REDACTED] at 2:08p.m. resident [REDACTED] pushed [REDACTED] call bell and waited 48 minutes for staff to answer and provide care. On

[REDACTED] at 5:58p.m. resident [REDACTED] pushed [REDACTED] call bell and waited 1 hour 17 minutes for staff to answer and provide care.

Resident [REDACTED]'s assessment and support plan, dated [REDACTED], indicates the resident is a two person transfer with a Hoyer lift and requires assistance with toileting. However, resident [REDACTED] indicates [REDACTED] has waited very long periods of time to receive assistance from staff and, at times, is assisted with transfers using the Hoyer lift with only 1 staff person.

Resident [REDACTED]'s call bell report indicates the resident did not receive assistance as required on numerous dates to include:

On [REDACTED] at 8:21a.m. resident [REDACTED] pushed [REDACTED] call bell and waited 1 hour 33 minutes for staff to answer and provide care.

On [REDACTED] at 2:09p.m. resident [REDACTED] pushed [REDACTED] call bell and waited 30 minutes for staff to answer and provide care. On

[REDACTED] at 7:10p.m. resident [REDACTED] pushed [REDACTED] call bell and waited 31 minutes for staff to answer and provide care. On

[REDACTED] at 8:34p.m. resident [REDACTED] pushed [REDACTED] call bell and waited 35 minutes for staff to answer and provide care. On

[REDACTED] at 3:51p.m. resident [REDACTED] pushed [REDACTED] call bell and waited 1 hour 13 minutes for staff to answer and provide care.

Repeated Violation - [REDACTED] et al., [REDACTED] et al.

Plan of Correction

Accept [REDACTED] - 04/28/2026)

Upon identification of the concern, the Community immediately reviewed both residents' assessments and individualized support plans to validate required services, including two-person transfers with a Hoyer lift and assistance with toileting. Staff were promptly re-educated on each resident's specific care needs, with emphasis on adherence to two-person transfer requirements and timely response to call bells. Staffing plans were reviewed and found to be in compliance with state regulations. To support ongoing compliance, the Community provided re-education to all direct care staff on following individualized service plans, expectations for timely call bell response, and appropriate escalation procedures when assistance is delayed or additional support is needed. The Community also implemented process improvements, including reinforcing call light response expectations during daily stand-up meetings, assigning staff zones to improve accountability, increasing nursing leadership oversight to validate compliance with transfer requirements, and evaluating staffing patterns to better align with resident acuity and

23a ADL assistance (continued)

peak care times. For monitoring, the Community will conduct daily audits of call bell response times with follow-up on any delays, weekly reviews of transfer documentation to confirm compliance with two-person assist requirements, and direct observation of staff by nursing leadership. Audit results will be reviewed weekly by the Executive Director and Health Services Director for four weeks and monthly thereafter, with additional coaching and education provided as needed.

Licensee's Proposed Overall Completion Date: 05/01/2026

Not Implemented [REDACTED] - 09/23/2026)

132h Designated meeting place**2. Requirements**

2800.

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

Multiple staff and resident interviews indicate that during some fire drills, residents requiring the transfer assistance of 2 staff using a Hoyer lift are not evacuated to a designated meeting place away from the building or within the fire-safe area.

Plan of Correction

Accepted [REDACTED] - 04/28/2026)

Upon identification of the concern, the Community conducted an immediate review of fire drill practices and confirmed that residents, including those requiring two-person assistance with a Hoyer lift, were evacuated during drills; however, documentation and validation of evacuation to the designated meeting place or fire-safe area was not consistently recorded. Staff were re-educated on fire drill requirements, including the need to both evacuate residents and accurately document their location during drills. The Community updated its fire drill documentation process to include resident-specific tracking to confirm evacuation location, including those requiring extensive assistance, and clarified staff roles to support safe and timely evacuation of high-acuity residents. To support ongoing compliance, the Community reinforced expectations during shift meetings and incorporated additional oversight by leadership during drills to validate that all residents are relocated appropriately and documented accordingly. For monitoring, the Executive Director and Health Services Director will review all fire drill documentation following each drill to confirm inclusion of all residents and their evacuation locations, with direct observation conducted during drills to validate practice. Any identified gaps will be addressed through immediate coaching and retraining, and drill documentation will be reviewed monthly to sustain compliance.

Licensee's Proposed Overall Completion Date: 05/01/2026

Not Implemented [REDACTED] - 09/23/2026)

187d Follow prescriber's orders**3. Requirements**

2800.

187.d. The residence shall follow the directions of the prescriber.

Description of Violation

Resident [REDACTED] was prescribed [REDACTED], give 1.5 tablets (15mg) by mouth one time daily for depression. On [REDACTED] resident [REDACTED]'s January 2026 Medication Administration Record indicated this medication was

187d Follow prescriber's orders (continued)

placed on hold, was not administered, and was discontinued and not administered on [REDACTED]. However, resident [REDACTED]'s provider did not discontinue or authorize a hold on this medication. Repeated Violation - [REDACTED]

Plan of Correction**Accepted [REDACTED] - 04/28/2026)**

Upon identification of the concern, the Community immediately completed a review of Resident [REDACTED]'s medication orders, Medication Administration Record (MAR), and prescribing provider documentation. The prescribing provider was contacted to clarify the order for Escitalopram, and the medication order was reconciled to align with current provider direction. The MAR was corrected to reflect the accurate order, and the medication was resumed as appropriate per provider guidance. A full audit of current residents' medication orders and MARs was conducted to identify any additional discrepancies related to medications being held or discontinued without proper provider authorization.

To support ongoing compliance, all licensed nurses and medication administration staff were re-educated on requirements for following prescriber orders, including that medications may not be held or discontinued without a documented provider order, and on proper documentation practices within the MAR. The Community reinforced its medication reconciliation process to require verification of provider orders prior to placing medications on hold or discontinuation, and clarified escalation procedures when there are questions regarding orders.

For monitoring, the Health Services Director or designee will complete weekly audits of MARs and provider orders for four weeks to confirm alignment between prescribed orders and administration documentation, with a focus on held or discontinued medications. Findings will be reviewed and trended, and any discrepancies will be addressed through immediate correction and staff coaching. Ongoing audits will continue monthly thereafter to sustain compliance.

Licensee's Proposed Overall Completion Date: 05/01/2026**Implemented [REDACTED] - 09/23/2026)**

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

Facility Information

Name: WESTLAKE WOODS AL **License #:** 45407 **License Expiration:** 06/10/2026
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:** L&I

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 69 **Waking Staff:** 52

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Complaint, Incident **Exit Conference Date:** 04/03/2026

Inspection Dates and Department Representative

03/26/2026 On Site: [REDACTED]
03/27/2026 On Site: [REDACTED]
04/03/2026 On Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 79 **Residents Served:** 49

Special Care Unit

In Residence: 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:** 49
Diagnosed with Mental Illness: 2 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 20 **Have Physical Disability:** 3

Inspections / Reviews

03/26/2026 Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/27/2026*

07/07/2026 - POC Submission

Submitted By: [REDACTED] Date Submitted: *07/17/2026*

Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *07/17/2026*

09/23/2026 - Document Submission

Submitted By: [REDACTED] Date Submitted: *07/17/2026*

Reviewer: [REDACTED] Follow-Up Type: *Enforcement*

23a ADL assistance**1. Requirements**

2800.

23.a. A residence shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident [REDACTED]'s assessment and support plan (ASP), dated [REDACTED], indicated the resident required assistance with bladder continence tasks with assistance of 2 (staff), and required transfer assistance using a 2-person Hoyer lift transfer. However, on [REDACTED] at approximately 7:00 a.m., staff person A transferred the resident from [REDACTED] bed to [REDACTED] chair with the Hoyer Lift without the assistance of a second staff person. In addition, the resident indicated [REDACTED] had extended wait times to receive assistance from staff after pressing [REDACTED] call bell. The resident's call bell report indicated that the resident did not receive assistance as required on the following dates, to include: On [REDACTED] at 2:14 p.m., the resident pressed [REDACTED] call bell and had to wait 26 minutes for staff to answer and provide care. The resident indicated [REDACTED] had skin irritation due to the wait. On [REDACTED] at 10:13 p.m., the resident pressed [REDACTED] call bell and had to wait 38 minutes for staff to answer and provide care. On [REDACTED], at 6:14 p.m., the resident pressed [REDACTED] call bell and had to wait 44 minutes for staff to answer and provide care. On [REDACTED] the resident pressed [REDACTED] call bell and had to wait 25 minutes for staff to answer and provide care.

Resident [REDACTED]'s ASP, dated [REDACTED] indicated that the resident required assistance with bladder continence tasks, required transfer assistance with a 2-person Hoyer lift, and required total assistance to evacuate for emergency preparedness and evacuation plan. However, the resident indicated that [REDACTED] had extended wait times to receive assistance from staff after pressing [REDACTED] call bell. The resident's call bell report indicated that the resident did not receive assistance as required on the following dates, to include: On [REDACTED], at 8:44 a.m., the resident pressed [REDACTED] call bell and had to wait 25 minutes for staff to answer and provide care. On [REDACTED] at 10:34 a.m., the resident pressed [REDACTED] call bell and had to wait 33 minutes for staff to answer and provide care. On [REDACTED] at 7:51 a.m., the resident pressed [REDACTED] call bell and had to wait 29 minutes for staff to answer and provide care. On [REDACTED] at 5:18 p.m., at 3:21 p.m., and at 2: 11 p.m., the resident pressed [REDACTED] call bell and had to wait 30 minutes, 27 minutes, and 30 minutes, respectively, for staff to answer and provide care. In addition, on [REDACTED], during the fire drill at 10:36 a.m., the resident was not evacuated and remained in [REDACTED] bed during the drill.

Repeated Violation - [REDACTED] et al. [REDACTED] et al.

Plan of Correction

Accept [REDACTED] - 07/07/2026)

Immediate Corrective Action:

On 04/06/2026, the Executive Director and Health and Wellness Director provided re-education to direct care staff regarding expectations for timely call bell response, completion of all Hoyer lift transfers with two (2) staff members present in accordance with resident support plans, and proper resident evacuation procedures during emergency preparedness drills. Education was completed during the Community crossover meeting, and attendance was documented.

Preventative/Systemic Changes:

To ensure ongoing compliance, the Executive Director, Health and Wellness Director, or designee will review call-bell response reports daily during Leadership Stand-Up meetings and direct care staff crossovers to identify and address

23a ADL assistance (continued)

any delays in response times. Any identified concerns will be addressed immediately through staff coaching, re education, and follow up monitoring.

Additionally, the Executive Director, Health and Wellness Director, or designee will conduct ongoing random resident interviews and direct observation audits to verify compliance with required two (2) person Hoyer lift transfers in accordance with resident support plans. Compliance with evacuation procedures will also be monitored through active fire drill observations and post drill staff and resident interviews to verify appropriate evacuation assistance.

Documentation of audits, interviews, observations, and corrective actions will be maintained. Monitoring will occur weekly for four (4) weeks and monthly thereafter to ensure sustained compliance.

Licensee's Proposed Overall Completion Date: 07/02/2026

Not Implemented - 09/23/2026)

42l Personal possessions**2. Requirements**

2800.

42.l. A resident has the right to furnish living unit and purchase, receive, use and retain personal clothing and possessions.

Description of Violation

The residence policy for Electronic Monitoring Devices, reviewed/revised indicated "The Community will allow for the installation and use of authorized electronic monitoring devices by a resident or resident's legal representative if: The Community is given advance written notice of the requested placement and use of an electronic monitoring device, which must include installation plan in compliance with the Community's protocols, which the Community provides to the resident upon request to place a device..." The Community will "Post a sign where authorized electronic monitoring is being conducted to alert and inform individuals entering the resident's apartment."

Plan of Correction

Accepted - 07/07/2026)

Immediate Corrective Action:

The Community's Policy and Procedure for Electronic Monitoring Devices was revised to reflect current BHSL guidance, confirming that residents may utilize personally owned electronic monitoring devices provided resident privacy is maintained and Community House Rules are followed. The Community respectfully clarifies that installation of a personally owned electronic monitoring device has never been denied.

Preventative/Systemic Changes:

The Executive Director re educated Leadership regarding resident rights associated with electronic monitoring devices and Community expectations surrounding privacy and House Rules compliance. The revised policy will be reviewed during resident admission and upon request by residents or responsible parties.

The Executive Director or designee will complete quarterly audits of resident concerns, grievances, and requests related to electronic monitoring devices to verify ongoing compliance with resident rights and Community policy. Any identified concerns will be addressed immediately through policy review, coaching, and follow up monitoring.

Licensee's Proposed Overall Completion Date: 07/02/2026

Implemented - 09/23/2026)

42u Right to remain in the residence

3. Requirements

2800.

42.u. A resident has the right to remain in the home, as long as it is operating with a license, except as specified in § 2600.228 (relating to notification of termination).

Description of Violation

On [REDACTED], the residence discharged resident [REDACTED] against resident's will for the resident's [REDACTED] violating the residence rules.

Plan of Correction

Directed [REDACTED] 07/07/2026)

Immediate Corrective Action:

The Executive Director was re-educated regarding requirements for issuing House Rule violations and appropriate documentation practices.

Preventative/Systemic Changes:

Beginning immediately, all House Rule violations will be reviewed by the Executive Director or designee prior to issuance to verify compliance with regulatory requirements and Community policy. Documentation audits will be conducted monthly to verify proper notification, documentation, and resident rights compliance. Any identified concerns will be addressed immediately through coaching, re-education, and follow-up monitoring.

Proposed Overall Completion Date: 07/02/2026

Directed:

By 7/14/26, the administrator will re-educate all staff on the Residence's current community handbook related to visitors and appropriate steps to be taken if a visitor is disruptive to resident care. The administrator or designated staff person will monitor any corrective actions taken related to visitors monthly, to ensure compliance.

[REDACTED] 7/7/26

Directed Completion Date: 07/14/2026

Implemented [REDACTED] - 09/23/2026)

51 Criminal background checks

4. Requirements

2800.

51. Criminal background checks

- 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).
- 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

Staff person B, the residence's administrator, was hired on [REDACTED]; however, the criminal background check was not completed until [REDACTED]. Additionally, staff person B did not live in Pennsylvania for the past 2 consecutive years, and an FBI background check was not completed.

Repeated Violation - [REDACTED] et al., [REDACTED] et al., [REDACTED] et al., [REDACTED] et al.

51 Criminal background checks (continued)

Plan of Correction

Accept [REDACTED] 07/07/2026)

Immediate Corrective Action:

The Community Administrator completed the Verified Credentials process on 03/27/2026 and received eligible results on 04/01/2026.

Preventative/Systemic Changes:

On 04/04/2026, the Executive Director completed an audit of all existing staff files to verify compliance with criminal background check requirements. Any identified missing or incomplete criminal background checks were immediately re processed and uploaded into employee personnel files.

Moving forward, the Executive Director or designee will audit all new hire files prior to the employee independently working to verify all required criminal background documentation is complete. Monthly personnel file audits will be conducted for ongoing compliance monitoring. Any identified concerns will be addressed immediately through corrective action and follow up monitoring.

Licensee's Proposed Overall Completion Date: 07/02/2026

Not Implemented [REDACTED] - 09/23/2026)

54a Direct care staff quals

5. Requirements

2800.

54.a. Direct care staff persons shall have the following qualifications:

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person D, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Repeated Violation - [REDACTED] et al., [REDACTED]

Plan of Correction

Accept [REDACTED] 07/07/2026)

Immediate Corrective Action:

On 03/26/2026, the Team Member was immediately suspended upon identification of the concern. Neither the Team Member nor the Community was aware that the diploma provided originated from an unaccredited diploma source.

Preventative/Systemic Changes:

On 04/04/2026, the Executive Director completed an audit of all existing direct care staff files to verify compliance with direct care staff qualification requirements. Any missing documentation was collected and uploaded into personnel files.

Moving forward, all educational documentation submitted during the hiring process will be verified prior to hire completion. The Executive Director or designee will conduct monthly personnel file audits to monitor ongoing compliance with direct care staff qualification requirements. Any identified concerns will be addressed immediately through corrective action, re-education, and follow-up monitoring.

54a Direct care staff quals (continued)

Licensee's Proposed Overall Completion Date: 07/02/2026

Implemented [REDACTED] - 09/23/2026)

65h 16 hrs annual training

6. Requirements

2800.

65.h. Direct care staff persons shall have at least 16 hours of annual training relating to their job duties. The training required in § 2800.69 (relating to additional dementia-specific training) shall be in addition to the 16 hour annual training.

Description of Violation

Direct care staff person C received only 15 hours and 53 minutes of annual training relating to [REDACTED] job duties during training year January 1, 2025 to December 31, 2025.

Direct care staff person D received only 15 hours and 32 minutes of annual training relating to [REDACTED] job duties during training year January 1, 2025 to December 31, 2025.

Plan of Correction

Accept [REDACTED] - 07/07/2026)

Immediate Corrective Action:

The Executive Director completed an audit of all existing staff annual training hours to verify compliance with annual training requirements on 03/26/2026.

Preventative/Systemic Changes:

Annual training topics will be incorporated into monthly Community Town Hall meetings with attendance documented. Staff unable to attend will be required to complete assigned training within an established timeframe.

The Executive Director, or designee will complete monthly audits of annual training hours and present findings during QAIP meetings to verify and monitor compliance. Any identified concerns will be addressed immediately through staff coaching, re-education, and follow-up monitoring.

Licensee's Proposed Overall Completion Date: 07/02/2026

Implemented [REDACTED] - 09/23/2026)

65j Annual training content

7. 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

Staff persons C & D did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during training year January 1, 2025 to December 1, 2025.

65j Annual training content (continued)

Plan of Correction

Accept [REDACTED] - 07/07/2026)

Immediate Corrective Action:

The Executive Director has scheduled a qualified Fire Safety Expert to provide the required annual fire safety training onsite on 07/16/2026.

Preventative/Systemic Changes:

Moving forward, the Executive Director will schedule required annual fire safety training in advance on a recurring yearly basis to ensure timely completion of all required annual training content. Training attendance and completion documentation will be maintained in employee records.

The Executive Director or designee will conduct annual audits of required training content completion to verify compliance. Any identified concerns will be addressed immediately through corrective action and follow up monitoring.

Licensee's Proposed Overall Completion Date: 07/16/2026

Implemented [REDACTED] - 09/23/2026)

65l Record of training

8. Requirements

2800.

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

The residence's record of direct care staff training for staff persons C & D does not include the length of the trainings.

Plan of Correction

Accept [REDACTED] 07/07/2026)

Immediate Corrective Action:

On 03/26/2026, Staff C and Staff D's training records were immediately corrected to include the length of the training sessions completed.

Preventative/Systemic Changes:

On 04/06/2026, the Executive Director completed an audit of training records to verify the documentation concern was isolated. The Community revised its training documentation process to include retention of training certificates and documentation reflecting all required regulatory components, including training length and completion verification.

The Executive Director or designee will complete monthly audits of training records to verify ongoing compliance with recordkeeping requirements. Any identified concerns will be addressed immediately through coaching, re education, and follow up monitoring.

Licensee's Proposed Overall Completion Date: 07/02/2026

Implemented [REDACTED] - 09/23/2026)

85a Sanitary conditions

9. Requirements

85a Sanitary conditions (continued)

2800.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On [REDACTED], there was a clear drinking cup and a small white container in the toilet of resident [REDACTED]'s bathroom.

Plan of Correction

Accepted [REDACTED] - 07/07/2026)

Immediate Corrective Action:

On 03/26/2026, the Community immediately corrected the concern upon identification by removing and disposing of the clear drinking cup and white container located in the resident bathroom.

Preventative/Systemic Changes:

Beginning 04/06/2026, the Community implemented verification of daily apartment refresh services completed by direct care staff. The Executive Director or designee will conduct random documented apartment spot checks to verify sanitary conditions are maintained.

Any identified concerns will be addressed immediately through staff coaching, re-education, corrective action, and follow-up monitoring. Monitoring will occur weekly for four (4) weeks and monthly thereafter.

Licensee's Proposed Overall Completion Date: 07/02/2026

Implemented [REDACTED] 09/23/2026)

95 Furniture & Equipment**10. Requirements**

2800.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On [REDACTED], the metal door sweep on emergency exit #1A was partially detached approximately 14 inches from the door, posing a potential tripping and skin tear hazard.

Plan of Correction

Accepted [REDACTED] - 07/07/2026)

Immediate Corrective Action:

On 03/26/2026, the Environmental Services Manager immediately corrected the metal door sweep concern during the survey walkthrough.

Preventative/Systemic Changes:

The Environmental Services Manager will complete and document weekly environmental safety walkthroughs to verify furniture, fixtures, and equipment remain clean, hazard-free, and in good repair.

95 Furniture & Equipment (continued)

Any identified concerns will be corrected immediately and addressed through staff coaching, re education, and follow up monitoring. The Executive Director or designee will review completed walkthrough documentation monthly to verify ongoing compliance.

Licensee's Proposed Overall Completion Date: 07/02/2026

Implemented [REDACTED] - 09/23/2026)

132c Fire drill records**12. 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

The fire drill record for the drill conducted on 3/25/26 at 10:36 a.m., indicated 20 residents were in the residence;

132c Fire drill records (continued)

however, 46 residents evacuated. In addition, the fire drill record does not include the number of residents with a mobility need.

Repeated Violation - [REDACTED] et al.

Plan of Correction

Accept [REDACTED] 07/07/2026)

Immediate Corrective Action:

The Executive Director reviewed the 03/25/2026 and verified the concern was related to a documentation error. The fire drill record was corrected to reflect accurate and complete regulatory information.

Preventative/Systemic Changes:

The Environmental Services Manager will complete fire drill documentation immediately following each drill. The Executive Director or designee will review all fire drill records for accuracy and completeness prior to filing.

Any identified concerns will be corrected immediately and addressed through coaching, re-education, and follow-up monitoring. Monthly audits of fire drill documentation will be conducted to verify ongoing compliance.

Licensee's Proposed Overall Completion Date: 07/02/2026

Implemented [REDACTED] - 09/23/2026)

132d Evacuation**13. 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

During the fire drill on [REDACTED] at 10:36 a.m., resident [REDACTED] was not evacuated, and remained in [REDACTED] bed during the drill.

Repeated Violation - [REDACTED] et al.

Plan of Correction

Accept [REDACTED] - 07/07/2026)

Immediate Corrective Action:

On 04/06/2026, the Executive Director and Health and Wellness Director provided re-education regarding proper evacuation procedures for residents requiring two-person Hoyer assistance during emergency preparedness drills. Education was completed during Community crossover and attendance was documented.

Preventative/Systemic Changes:

The Executive Director or designee will monitor evacuation compliance during active fire drills through direct observation to verify residents requiring two-person assistance are evacuated in accordance with regulatory requirements and resident support plans. Post-drill resident and staff interviews will also be conducted to verify compliance.

132d Evacuation (continued)

Any identified concerns will be addressed immediately through coaching, re-education, corrective action, and follow-up monitoring. Drill observations and interviews will be documented and maintained for ongoing compliance monitoring.

Licensee's Proposed Overall Completion Date: 07/02/2026

Implemented [REDACTED] - 09/23/2026)

144c1 Smoking area guidelines**14. Requirements**

2800.

144.c. A residence that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the residence, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The residence's designated smoking area did not have fireproof receptacle or ashtray, and there were 6 cigarette butts on the table, and one cigarette on the ground under the table.

Plan of Correction

Accept [REDACTED] - 07/07/2026)

Immediate Corrective Action:

The Community immediately corrected the concern upon identification and replaced the fireproof receptacle/ashtray while surveyors were onsite.

Preventative/Systemic Changes:

Beginning 05/26/2026, the Environmental Services Manager will complete documented weekly safety walkthroughs to verify fireproof smoking receptacles remain in place and in good condition. Backup receptacles were purchased to ensure immediate replacement availability if needed. Any identified concerns will be corrected immediately and addressed through staff coaching, re-education, and follow-up monitoring. The Executive Director or designee will review safety walkthrough documentation monthly to verify ongoing compliance.

Licensee's Proposed Overall Completion Date: 07/02/2026

Implemented [REDACTED] 09/23/2026)

183b Medications and syringes locked**15. 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] resident [REDACTED]'s eye drops were on a bedside table. The resident indicated [REDACTED] always leaves them there unlocked, unattended, and accessible.

Repeated Violation - [REDACTED] et al.

183b Medications and syringes locked (continued)

Plan of Correction**Accept (SQ - 07/07/2026)***Immediate Corrective Action:*

The resident had a physician order authorizing self administration of eye drops. The Executive Director re educated the resident regarding regulatory requirements to secure self administered medications when not in use; the education was documented within the resident's record. The resident obtained a lockable storage mechanism for medication storage.

Preventative/Systemic Changes:

Beginning 05/26/2026, the Executive Director, Health and Wellness Director, or designee will complete weekly audits of residents authorized to self administer medications to verify medications remain secured in accordance with regulatory requirements.

Any identified concerns will be addressed immediately through resident education, coaching, corrective action, and follow up monitoring. Documentation of audits and corrective actions will be maintained for ongoing compliance verification.

Licensee's Proposed Overall Completion Date: 07/02/2026

Implemented [REDACTED] 09/23/2026)

228h Grounds-discharge/transfer

16. Requirements

2800.

228.h. The only grounds for transfer or discharge of a resident from a residence are for the following conditions:

1. If a resident is a danger to himself or others and the behavior cannot be managed through interventions, services planning or informed consent agreements.
2. If the legal entity chooses to voluntarily close the residence, or a portion of the residence.
3. If the legal entity chooses to voluntarily close the residence, or a portion of the residence.
4. If meeting the resident's needs would require a fundamental alteration in the residence's program or building site, or would create an undue financial or programmatic burden on the residence.
5. If the resident has failed to pay after reasonable documented efforts by the residence to obtain payment.
6. If closure of the residence is initiated by the Department.
7. Documented, repeated violation of the residence rules.
8. A court has ordered the transfer or discharge.

Description of Violation

On [REDACTED], the residence issued a 30 day notice of discharged, and on [REDACTED] discharged the resident against the resident's will. The resident was discharged due to the resident's [REDACTED] violating residence rules related to inappropriate use of the camera in the apartment" and not for any permitted conditions.

Plan of Correction**Directed [REDACTED] - 07/07/2026)***Immediate Corrective Action:*

The Community reviewed the discharge documentation. The Community Residency Agreement/Contract outlines the standards of conduct: Resident agrees that Resident, family members, guests, and other invitees will abide by the rules of Community and standards of conduct for visitors and will not commit, perform or allow any act in or about the Leased Premises or Community that is illegal, unlawful, criminal, or in violation of any municipal, state or federal law, ordinance, or regulation, including but not limited to threatening, intimidation, or assaultive behavior, and unlawful possession, ownership, or discharge of firearms and ammunitions; engagement in drug related criminal

228h Grounds discharge/transfer (continued)

activity, including but not limited to, using or possessing non prescribed controlled substances or illegal drugs; or interference with Community's management and operation of Community. Resident understands that failure to abide by such rules and regulations shall constitute good cause for Community's termination of this Agreement.

Preventative/Systemic Changes:

Moving forward, all discharge and transfer notices related to House Rule violations will be reviewed by the Executive Director and Regional Leadership prior to issuance to verify regulatory compliance, supporting documentation, and resident rights requirements are met. The Executive Director or designee will complete quarterly audits of discharge and transfer documentation to verify ongoing compliance with regulatory requirements. Any identified concerns will be addressed immediately through corrective action, re education, and follow up monitoring.

Proposed Overall Completion Date: 07/02/2026

Directed:

By 7/14/26, the administrator will re educate all staff on the Residence's current Community Handbook related to visitors and appropriate steps to be taken if a visitor is disruptive to resident care. The administrator or designated staff person will monitor any corrective actions taken related to visitors monthly, to ensure compliance. Prior to any resident discharge related to a visitor's conduct, immediate actions outlined in the community handbook related to visitors shall be followed and documentation shall be kept. Additionally, any resident who is in jeopardy of potential discharge due to a residence rules violation related to visitor conduct will be immediately notified on the first offense and all possible attempts will be made to address the situation without discharging the resident.

7/7/26

Directed Completion Date: 07/14/2026

Implemented - 09/23/2026)

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

Facility Information

Name: WESTLAKE WOODS AL **License #:** 45407 **License Expiration:** 06/10/2026
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:** Labor and Industry

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 78 **Waking Staff:** 59

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Complaint, Provisional, Incident, Fine **Exit Conference Date:** 05/07/2026

Inspection Dates and Department Representative

05/05/2026 - On-Site: [REDACTED]
05/06/2026 - On-Site: [REDACTED]
05/07/2026 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 79 **Residents Served:** 55

Special Care Unit

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

Hospice

Current Residents: 8

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 55
Diagnosed with Mental Illness: 3 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 23 **Have Physical Disability:** 3

Inspections / Reviews

05/05/2026 Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *05/25/2026*

07/07/2026 - POC Submission

Submitted By: [REDACTED] Date Submitted: *07/17/2026*
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *07/17/2026*

09/23/2026 - Document Submission

Submitted By: [REDACTED] Date Submitted: *07/17/2026*
Reviewer: [REDACTED] Follow-Up Type: *Enforcement*

23a ADL assistance

1. Requirements

2800.

23.a. A residence shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident [REDACTED]'s initial Service Plan Report, dated [REDACTED], indicates resident [REDACTED] requires the assistance of two team members for transfer and one team member to assist with showers. However, according to numerous staff and resident interviews, the residence staff have not provided resident [REDACTED] a shower since admission on [REDACTED] 6 because the resident does not have a wheeled shower chair, the residence has only been providing bed baths.

Resident [REDACTED]'s initial Service Plan Report, dated [REDACTED], indicates resident [REDACTED] requires transfer assistance using a 2-person Hoyer lift transfer. However, on [REDACTED] during the 2:00 PM to 10:30 PM shift, staff person A transferred resident [REDACTED] from the wheelchair to the bed without assistance from a second staff person.

Repeated Violation – [REDACTED] et al. [REDACTED] et al.

Plan of Correction

Accept [REDACTED] - 07/07/2026)

Immediate Action: The Resident, per preference, has received bed baths since move in. Upon identification of the concern, Resident [REDACTED]'s bathing needs and transfer needs were immediately reviewed by the Executive Director and Health and Wellness Director. A wheeled shower chair was obtained by the resident, and bathing services with the chair were initiated in accordance with assessed needs. The Health and Wellness Director implemented a PRN bed bath service on the resident's care plan to ensure appropriate documentation should the resident again prefer a bed bath service.

Corrective Action: On 6/1/2026 Staff received documented re-education regarding compliance with Service Plans, bathing assistance, and two-person transfer requirements.

Preventative/Systemic Changes to Prevent Recurrence: The Executive Director, Health and Wellness Director, or designee will conduct audits of resident bathing documentation and transfer documentation weekly for four (4) weeks to verify scheduled showers are completed per Service Plan, required DME is available and utilized and two-person transfers are completed as required.

Any identified deficiencies will be corrected immediately through staff coaching, re-education, and documentation review.

Licensee's Proposed Overall Completion Date: 06/26/2026

Not Implemented [REDACTED] - 09/23/2026)

23b IADL assistance

2. Requirements

2800.

23.b. A residence shall provide each resident with assistance with IADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident [REDACTED]'s initial Service Plan Report, dated [REDACTED], indicates resident [REDACTED] requires transfer assistance using a 2-person Hoyer lift transfer and uses a motorized scooter, community will assist resident in all transportation needs.

Resident [REDACTED]'s contract, dated [REDACTED] includes "weekly transportation option that permits resident to schedule medical and social appointment within a reasonable local area." However, according to resident [REDACTED] and multiple staff

23b IADL assistance (continued)

interviews, transportation has not been provided because resident ■■■ uses a power wheelchair, and the residence does not transport any resident in a power wheelchair.

Plan of Correction

Accept ■■■ - 07/07/2026)

Immediate Action: Upon identification of the concern, the Executive Director immediately reviewed Resident ■■■'s transportation needs, Residency Agreement, and Service Plan to ensure compliance. Per the Residency Agreement, the Community provides transportation to and from appointments, based on availability. However, the agreement does not specify that transportation must occur while a resident remains seated in an electronic wheelchair.

Corrective Action: Resident ■■■'s transportation needs were reviewed. Transportation procedures were reviewed to ensure transportation services are provided consistent with resident agreements and assessed needs.

Preventative/Systemic Changes to Prevent Recurrence: The Community will update the Community Handbook (House Rules) to specify that the van cannot transport electric wheelchairs for safety reasons in accordance with the manufacturer instructions and that for transportation needs to be met, the resident will be required to use a manual wheelchair during Community assisted transportation. Deficiencies will be corrected immediately through reassessment and Service Plan updates.

Licensee's Proposed Overall Completion Date: 05/29/2026

Implemented ■■■ - 09/23/2026)

42b Abuse/Neglect**3. Requirements**

2800.

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

Resident ■■■'s medical evaluation, dated ■■■, includes a diagnosis of Dementia and resident ■■■'s Service Plan Report, dated ■■■ indicates the resident needs assistance in unfamiliar places and the residence will provide supervision per assessed need. Multiple staff interviews indicated that resident ■■■ wanders throughout the residence. Resident ■■■'s Service Plan Report also indicates for the resident's mobility and transfer needs, the Community provides resident ■■■ with escorts to/from locations other than meals with assistance of one staff.

On ■■■ at approximately 6:15 AM, staff person B went to administer medications to resident ■■■ and the resident was not in the resident's apartment. Numerous staff working could not find resident ■■■ and a search of the residence was conducted. According to Staff person C, the Residence's Administrator, the last check on resident ■■■ by staff was at 2:40 AM. At approximately 6:50 AM, staff found resident ■■■ sleeping while lying on the floor of the first-floor common bathroom after a fall. Resident ■■■ had fallen sometime during the night and could not get up from the floor. Staff woke resident ■■■ who was dressed only in a shirt, socks and glasses. Resident ■■■ sustained visible injuries to include multiple bruises to the forehead, nose, and elbow, and was bleeding from the left elbow. Staff assisted resident ■■■ from the floor and indicated that resident ■■■ appeared to have been on the floor for an extended period of time. Resident ■■■ indicated headache pain, was assessed with confusion, and was only oriented to person. Resident ■■■ was transported to the hospital by ambulance and was admitted to the intensive care unit where ■■■ was diagnosed with a 2-column fracture at spine, T12 burst fracture, head, neck, and back trauma, bradycardia, and elevated lactic acid and troponin levels.

Repeated Violation—■■■ et al., ■■■ et al., ■■■ et al.

42b Abuse/Neglect (continued)**Plan of Correction**

Accept [REDACTED] - 07/07/2026)

Immediate Action: Upon discovery of the incident, Resident [REDACTED] received immediate support and emergency medical treatment. The resident was transported to the hospital, and appropriate notifications were completed per regulatory compliance. The Executive Director and Health and Wellness Director reviewed the residents support plan and insured compliance with documentation of services provided to resident, including "I'm OK checks", which were appropriately documented and provided by staff on the night of the incident.

Corrective Action: Resident [REDACTED]'s assessment and Service Plan were reviewed to ensure compliance with behavior interventions, safety checks, and fall prevention interventions. Staff received re-education regarding abuse and neglect on 04/21/2026 by the Executive Director.

Preventative/Systemic Changes to Prevent Recurrence: The Executive Director, Health and Wellness Director, or designee will complete weekly audits of incident reports and Service Plans to ensure interventions are implemented for four (4) weeks to ensure continued compliance. Any deficiencies identified will result in immediate corrective action, retraining, and documentation review.

Licensee's Proposed Overall Completion Date: 06/26/2026

Implemented [REDACTED] - 09/23/2026)

60a Staffing/support plan needs**4. Requirements**

2800.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan. Residence staff or service providers who provide services to the residents in the residence shall meet the applicable professional licensure requirements.

Description of Violation

On [REDACTED], there were 54 residents present in the residence, including 23 residents with mobility needs. Of the 23 residents with mobility needs, 8 of the residents require the physical assistance of 2 staff persons to transfer in/out of bed/chair. According to the most recent documentation from a fire safety expert, dated [REDACTED], the maximum evacuation time to the residence's numerous internal fire-safe areas is 18 minutes. The residence routinely schedules 4 staff persons in the home during the 10:00 PM through 6:30 AM shift, which is not adequate to evacuate all residents in an emergency. Additionally, the residence conducted a fire drill using only 4 staff persons on [REDACTED] at 5:27 AM; however, the evacuation time for that fire drill was completed in 22 minutes, which exceeds the current maximum evacuation time.

Repeated Violation- [REDACTED] et al.

Plan of Correction

Accept [REDACTED] - 07/07/2026)

Immediate Action: The Executive Director reviewed staffing schedules and evacuation procedures immediately upon identification of the deficiency.

Corrective Action: The residence completed a staffing analysis and emergency preparedness review to determine staffing levels necessary to safely evacuate residents within the approved evacuation timeframe. The Executive Director and Environmental Services Manager completed a fire drill on the NOC shift to ensure that compliance was met and the community showed ability to safely evacuate residents within the required time per regulatory compliance.

Preventative/Systemic Changes to Prevent Recurrence: The Executive Director or designee will review all fire drill records for the next six (6) months to ensure that staffing levels and emergency preparedness policies and

60a Staffing/support plan needs (continued)

procedures are met per regulatory compliance and safe evacuation times are met consistently. Emergency preparedness procedures and evacuation readiness will be reviewed in monthly Quality Assurance Improvement Plan (QAIP) meetings monthly.

Any identified deficiencies will be corrected immediately.

Licensee's Proposed Overall Completion Date: 06/26/2026

Implemented [REDACTED] - 09/23/2026)

81b Resident equip – good repair**5. 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 attached to resident [REDACTED]'s bed was not secure and moved approximately 2-3 inches back and forth.

On [REDACTED], the bed enabler attached to resident [REDACTED]'s bed was not secure and moved approximately 2-3 inches back and forth.

Repeated Violation – [REDACTED] et al., [REDACTED] et al.

Plan of Correction

Accepted [REDACTED] - 07/07/2026)

Immediate Action: The bed enablers for Residents [REDACTED] and [REDACTED] were immediately addressed to ensure safety and secured according to manufacturer specifications.

Corrective Action: All resident bed enablers and assistive devices were inspected to ensure safety on 6/1/2026. Staff were re-educated on escalation processes regarding bed enablers that are unsecured on 6/1/2026.

Preventative/Systemic Changes to Prevent Recurrence: The Health and Wellness Director or designee will conduct weekly audits of all bed enablers, grab bars, and resident assistive devices for four (4) weeks to verify equipment remains secure and functioning properly.

Deficiencies identified will be corrected immediately and documented.

Licensee's Proposed Overall Completion Date: 06/26/2026

Implemented [REDACTED] 09/23/2026)

82a Poisons original containers**6. Requirements**

2800.

82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On [REDACTED], there was an unlabeled plastic spray bottle, full of purple liquid, on the toilet tank in resident [REDACTED]'s private bathroom.

Plan of Correction

Accepted [REDACTED] 07/07/2026)

Immediate Action: Upon identification of the concern, the unlabeled plastic spray bottle was removed from the

82a Poisons original containers (continued)

resident's apartment and the resident was educated on regulatory requirement to keep all chemicals in original, labeled containers.

Corrective Action: On 6/1/2026, a full inspection of residents apartments in regard to items being within their original, labeled containers was completed. Any deficiencies will be addressed.

Preventative/Systemic Changes to Prevent Recurrence: The Environmental Services Manager or designee will conduct weekly environmental safety audits for four (4) weeks. Education will be provided to Residents regarding regulatory requirement to store materials in their original, labeled containers.

Any deficiencies identified will be corrected immediately.

Licensee's Proposed Overall Completion Date: 06/26/2026

Implemented [REDACTED] 09/23/2026)

85a Sanitary conditions**7. Requirements**

2800.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On [REDACTED] at approximately 9:30 AM, there was a used soiled glove on the floor near the 1 B emergency exit door.

Plan of Correction

Accept [REDACTED] - 07/07/2026)

Immediate Action: Upon identification of the concern, the soiled glove was immediately removed and disposed of according to infection control procedures.

Corrective Action: On 6/1/2026, Staff received re education regarding infection control, housekeeping expectations, and proper disposal of personal protective equipment.

Preventative/Systemic Changes to Prevent Recurrence: The Executive Director, Environmental Services Manager, or designee will conduct environmental rounds weekly for four (4) weeks to verify hallways and common areas are free of debris, PPE is properly discarded and sanitary conditions are maintained throughout the residence.

Any deficiencies identified will be corrected immediately.

Licensee's Proposed Overall Completion Date: 06/26/2026

Implemented [REDACTED] - 09/23/2026)

88a Floors, walls, ceilings, windows, doors**8. 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] there was an approximate 3 inch by 5 inch hole in resident [REDACTED]'s apartment in the wall opposite resident [REDACTED]'s television.

Plan of Correction

Accept [REDACTED] - 07/07/2026)

Immediate Action: Upon identification of the concern, the hole in the resident's apartment was immediately addressed and repaired.

Corrective Action: On 6/1/2026, a full inspection of resident room wall was completed. Any deficiencies will be addressed and repaired.

Preventative/Systemic Changes to Prevent Recurrence: The Environmental Services Manager or designee will

88a Floors, walls, ceilings, windows, doors (continued)

conduct weekly environmental safety audits for four (4) weeks. Residents will be educated on the requirement to immediately notify the Environmental Services Director if repairs are needed outside of audit timeframes. Any deficiencies identified will be corrected immediately.

Licensee's Proposed Overall Completion Date: 06/26/2026

Implemented [REDACTED] - 09/23/2026)

95 Furniture & Equipment**9. Requirements**

2800.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On [REDACTED] the electrical outlet behind resident [REDACTED]'s bed was detached from the wall electrical cords were hanging and wires were exposed, posing a safety hazard.

Plan of Correction

Accepted [REDACTED] - 07/07/2026)

Immediate Action: Upon identification of the concern, the damaged electrical outlet was immediately removed from service and replaced while the surveyor was present.

Corrective Action: On 6/1/2026, a full inspection of resident room electrical outlets and visible wiring was completed. Any deficiencies will be addressed by replacement.

Preventative/Systemic Changes to Prevent Recurrence: The Environmental Services Manager or designee will conduct weekly environmental safety audits for four (4) weeks and verify all electrical outlets, cords, and equipment are maintained in safe operating condition. Residents will be educated on the requirement to immediately notify the Environmental Services Director if repairs are needed outside of audit timeframes. Any deficiencies identified will be corrected immediately.

Licensee's Proposed Overall Completion Date: 06/26/2026

Implemented [REDACTED] 09/23/2026)

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

The residence's most recent fire safety inspection conducted by a fire safety expert on [REDACTED] indicates the maximum safe evacuation time to the residence's multiple fire-safe areas is 18 minutes. However, the residence exceeded the maximum safe evacuation time of 18 minutes during the fire drill conducted on [REDACTED] at 5:27 AM, with an evacuation time of 22 minutes.

Repeated Violation – [REDACTED] et al.

Plan of Correction

Accepted [REDACTED] - 07/07/2026)

Immediate Action: The Executive Director reviewed staffing schedules and evacuation procedures immediately

132d Evacuation (continued)

upon identification of the deficiency.

Corrective Action: The residence completed a staffing analysis and emergency preparedness review to determine staffing levels necessary to safely evacuate residents within the approved evacuation timeframe. The Executive Director and Environmental Services Manager completed a fire drill on the NOC shift to ensure that compliance was met, and the community showed ability to safely evacuate residents within the required time per regulatory compliance.

Preventative/Systemic Changes to Prevent Recurrence: The Executive Director or designee will review all fire drill records for the next six (6) months to ensure that staffing levels and emergency preparedness policies and procedures are met per regulatory compliance. Emergency preparedness procedures and evacuation readiness will be reviewed in monthly Quality Assurance Improvement Plan (QAIP) meetings monthly.

Any deficiencies identified will be addressed immediately through retraining and process revision.

Repeated Violation - 07/29/2025 et al.

Licensee's Proposed Overall Completion Date: 06/26/2026

Implemented [REDACTED] - 09/23/2026)

161b Well-balanced meals**11. Requirements**

2800.

161.b. At least three nutritionally well-balanced meals shall be offered daily to the resident. Each meal shall include an alternative food and drink item from which the resident may choose.

Description of Violation

On [REDACTED] resident [REDACTED] was not offered breakfast, a meal was not provided until 10:00 AM when a staff person prepared toast when morning medications were administered to resident [REDACTED]

Plan of Correction

Accepted [REDACTED] - 07/07/2026)

Immediate Action: The Executive Director investigated upon identification of the concern. Resident [REDACTED]'s breakfast meal service was provided at 10am. The resident exercised [REDACTED] right to refuse a meal at the time it was served and instead opted to have toast. This does not construe a violation of 161b.

Corrective Action: On 06/01/2026, meal service procedures were reviewed with dietary and direct care staff to ensure all residents are offered meals at scheduled mealtimes and processes regarding refusals and documentation.

Preventative/Systemic Changes to Prevent Recurrence: The Executive Director, Culinary Manager, or designee will audit meal service documentation weekly for four (4) weeks and conduct weekly resident interviews regarding meal service.

Any deficiencies identified will be corrected immediately through staff re-education and corrective action.

Licensee's Proposed Overall Completion Date: 06/26/2026

Implemented [REDACTED] - 09/23/2026)

227a Final support plan – 30 days**12. Requirements**

2800.

227.a. Each resident requiring services shall have a written final support plan developed and implemented within 30 days after admission to the residence. The final support plan shall be documented on the Department's support plan form.

Description of Violation

According to resident [REDACTED] and numerous staff, resident [REDACTED] has not been provided with a shower since admission on

227a Final support plan – 30 days (continued)

Resident [REDACTED] has only been provided bed baths because resident [REDACTED] does not have a wheeled shower chair available. However, resident [REDACTED]'s initial Service Plan Report, dated [REDACTED], does not include how current bathing needs will be met, it only includes "will maintain hygiene and cleanliness with the assistance of two team members for transfer and one team member for the assist of the shower. Resident will be encouraged to complete any parts of bathing/showering when able to do so safely, Interventions: Community provides resident [REDACTED] scheduled bathing assistance." Also, resident [REDACTED]'s Service Plan Report does not include Frequency of Care for numerous care needs to include grooming, bathing, dressing, and activities/socialization. Additionally, resident [REDACTED]'s Support Plan Report does not address the care needs to meet numerous diagnoses listed on the medical evaluation (DME) dated [REDACTED] and listed on the Service Plan Report dated [REDACTED] to include hyperlipidemia, gastro-esophageal reflux disease, major depressive disorder, and disease of spinal cord.

Plan of Correction**Accept [REDACTED] - 07/07/2026)**

Immediate Action: Resident [REDACTED]'s Service Plan was immediately reviewed and revised to accurately reflect bathing interventions, frequency of care, equipment needs, diagnoses, and support requirements.

Corrective Action: On 06/01/2026, the Health and Wellness Director completed a comprehensive review of Resident [REDACTED]'s assessment, medical evaluation, and Service Plan was completed to ensure all identified needs were addressed.

Preventative/Systemic Changes to Prevent Recurrence: The Health and Wellness Director, Executive Director, or designee will audit new admission Service Plans, frequency of care documentation and diagnosis specific interventions. Audits will be completed and documented weekly for four (4) weeks. Any deficiencies identified will be corrected immediately.

Licensee's Proposed Overall Completion Date: 06/26/2026

Implemented [REDACTED] - 09/23/2026)**227c Final support plan - revision****13. Requirements**

2800.

227.c. The final support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment. The residence shall review each resident's final support plan on a quarterly basis and modify as necessary to meet the resident's needs.

Description of Violation

Resident [REDACTED]'s Service Plan Report, dated [REDACTED], had not been reviewed quarterly, the residence only has documentation of quarterly Assessment reviews.

Plan of Correction**Accept [REDACTED] - 07/07/2026)**

Immediate Action: Resident [REDACTED]'s Service Plan was immediately reviewed, along with additional move in, 30 day and quarterly assessments. Resident [REDACTED] moved in on 9/4/2025. From there, the Resident was assessed at 30 days, quarterly thereafter. The dates of these assessments were 9/4/2025, 10/6/2025, 12/8/2025, and 3/6/2026. The resident was receiving documented service plan reviews in line with 227c requirements.

Corrective Action: On 06/01/2026, the Health and Wellness Director completed a review of residents requiring quarterly Service Plan reviews to ensure compliance.

Preventative/Systemic Changes to Prevent Recurrence: The Health and Wellness Director or designee will audit quarterly Service Plan reviews weekly for four (4) weeks and verify required reviews are completed in a timely manner.

227c Final support plan - revision (continued)

Any deficiencies identified will be corrected immediately.

Licensee's Proposed Overall Completion Date: 06/26/2026

Implemented [REDACTED] - 09/23/2026)

227d Support plan – med/dental**14. Requirements**

2800.

227.d. Each residence shall document in the resident's final support plan the dietary, medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

Description of Violation

Resident [REDACTED]'s Service Plan Report, dated [REDACTED], does not address the care needs or frequency to meet numerous diagnoses listed on the medical evaluation (DME) dated [REDACTED] and listed on the Service Plan Report dated [REDACTED], to include [REDACTED] and [REDACTED].

Repeated Violation – [REDACTED] et al.

Plan of Correction

Accept [REDACTED] - 07/07/2026)

Immediate Action: Resident [REDACTED]'s Service Plan was immediately revised to address all diagnoses and corresponding care needs. Per communication with the Department during a previous survey, only relevant diagnoses impacting the resident's care need to be listed on the ASP. It is the Community's understanding that diagnoses that do not impact the care plan for the resident do not need to be listed (e.g., hyperlipidemia).

Corrective Action: On 06/01/2026, the Health and Wellness Director completed a review of resident assessments, medical evaluations, and Service Plans to ensure relevant diagnoses are addressed.

Preventative/Systemic Changes to Prevent Recurrence: The Health and Wellness Director or designee will audit Service Plans weekly for four (4) weeks and verify diagnoses, interventions, and frequencies of care are reflected accurately.

Deficiencies identified will be corrected immediately.

Licensee's Proposed Overall Completion Date: 06/26/2026

Implemented [REDACTED] 09/23/2026)

227h Support plan – refusal sign**15. Requirements**

2800.

227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident [REDACTED]'s most recent Support Plan is not signed by the resident or noted by the residence that the resident refused or was unable to sign.

227h Support plan – refusal sign (continued)

Plan of Correction**Accept** [REDACTED] 07/07/2026)

Immediate Action: Resident [REDACTED]'s Service Plan was reviewed with the resident, and signature status was documented appropriately on 06/01/2026.

Corrective Action: Beginning 06/01/2026, the Health and Wellness Director and Executive Director will review all resident Service Plans to verify signatures or documented refusals/inability to sign. Any service plans without a signature or documentation of refusal of signature will be obtained with a compliance date of 06/30/2026.

Preventative/Systemic Changes to Prevent Recurrence: The Health and Wellness Director or designee will audit Service Plans weekly for four (4) weeks and verify resident signatures or documented refusal/inability to sign are present.

Any deficiencies identified will be corrected immediately through documentation updates and staff re education.

Licensee's Proposed Overall Completion Date: 06/30/2026

Implemented [REDACTED] - 09/23/2026)