





# Pennsylvania Department of Human Services

Emailing Date: May 19, 2026

[REDACTED]  
Abode Care of Monroeville LLC  
[REDACTED]

RE: Abode Care of Monroeville  
License #: 451190

[REDACTED]:  
As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on March 9, 2026, and March 10, 2026, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala  
Deputy Secretary  
Office of Long-term Living

Enclosures  
License  
Licensing Inspection Summary

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

**Facility Information**

Name: *ABODE CARE OF MONROEVILLE* License #: *45119* License Expiration: *06/19/2026*  
Address: *2560 STROSCHEIN ROAD, MONROEVILLE, PA 15146*  
County: *ALLEGHENY* Region: *WESTERN*

**Administrator**

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

**Legal Entity**

Name: *ABODE CARE OF MONROEVILLE LLC*  
Address: [REDACTED]  
Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *1 2* Date: *06/04/2012* Issued By: *Municipality of Monroeville*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *56* Waking Staff: *42*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
Reason: *Renewal, Complaint, Provisional* Exit Conference Date: *03/10/2026*

**Inspection Dates and Department Representative**

03/09/2026 On Site: [REDACTED]  
03/10/2026 On Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *66* Residents Served: *34*

**Secured Dementia Care Unit**

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

**Hospice**

Current Residents: *4*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *33*  
Diagnosed with Mental Illness: *4* Diagnosed with Intellectual Disability: *1*  
Have Mobility Need: *22* Have Physical Disability: *1*

**Inspections / Reviews**

**03/09/2026 - Full**

Lead Inspector: [REDACTED] Follow Up Type: *POC Submission* Follow Up Date: *04/12/2026*

04/14/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/24/2026

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 04/20/2026

04/23/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/24/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission

Follow Up Date: 04/24/2026

05/14/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/24/2026

Reviewer: [REDACTED]

Follow Up Type: Exception

## 25b - Contract Signatures

## 1. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

## Description of Violation

Resident [REDACTED]'s resident-home contract, dated [REDACTED] is not signed by resident [REDACTED]

REPEAT VIOLATION: [REDACTED], et. al.

## Plan of Correction

Accepted [REDACTED] - 04/23/2026)

On 03/10/26, Immediately following the inspection, the Administrator reviewed the resident's contract with the resident and obtained the required signatures, ensuring compliance with 55 Pa. Code § 2600.25(b), which mandates signatures from the resident, the administrator/designee, the payer (if different), and the designated person if applicable.

On 03/16/26 the Administrator completed an audit on all resident records to ensure all records have the required signatures.

Any area of deficiencies were corrected.

On 03/13/26 the Executive Director facilitated a training with the new Admissions Director, the Director of Wellness and Assistant Director of Wellness to review the full admissions process that includes what documentation must be present prior to a resident admission and reviewed by the Administrator and Admissions Director. This documentation includes a fully signed contract. Moving forward, the Admissions Director and Administrator will be responsible to both check the file prior to admission to ensure full compliance.

There will be a file checklist in each file for the Administrator or designee to sign off and acknowledge completeness. The check list will begin for all new admissions starting on 3-14-2026. A secondary, (double check) will be completed within 4hrs of the admission for all new admissions, by Administrator.

On April 24, 2026, our quarterly quality meeting will take place. Review of 2600.26b and plan of corrections will be included as topics. Documentation of the review will be kept.

The home maintains a Quality Management Plan that includes the periodic review and evaluation of reportable incident and condition reporting, complaint procedures, staff training, licensing violations and plans of correction, and resident or family council concerns, as applicable. Admission and resident record audits are incorporated into this process to monitor compliance with regulatory requirements and identify areas needing improvement.

All records will be kept in the Administrators office for DHS inspection.

Proposed Overall Completion Date: 04/24/2026

Licensee's Proposed Overall Completion Date: 04/24/2026

Implemented [REDACTED] - 05/14/2026)

## 41e - Signed Statement

## 2. Requirements

2600.

41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

## Description of Violation

Resident [REDACTED] record does not contain a statement signed by resident [REDACTED] acknowledging receipt of a copy of the resident rights and complaint procedures.

## Plan of Correction

Accept [REDACTED] - 04/23/2026)

In response to the violation on 03/09/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on March 10, 2026, by the Administrator who met with Resident [REDACTED]. During this meeting, the Administrator read the Resident Rights and Complaint Procedures aloud to the resident. At this time the Administrator provided the resident with a printed copy of the Resident Rights and Complaint Procedures. Resident [REDACTED] signed a written acknowledgment confirming receipt and understanding of resident rights. The signed acknowledgment was placed in the resident's permanent record by the Administrator on 03/10/26. Following identification of the deficiency, the Administrator conducted an audit on 03/16/26 of all active resident records to determine whether any other files lacked: A signed admission agreement, a signed acknowledgment of receipt of Resident Rights and Complaint Procedures. On 04/08/26 during resident meeting the residents were all presented a review of the residents' rights as an added measure to ensure all residents received a copy and understood their rights. Signatures were obtained and will be kept in the residents' records located in the administrator's office.

On 03/13/26 the administrator retrained the new Admissions Director, Director of Wellness, Assistant Director of Wellness on the admissions procedure to include that a full signed contract with the residents' rights should be completed and provided to the Executive Director or Designee for review prior to admission. The Executive Director and Admissions Director will be responsible to both check the file and signoff on completion and accuracy in accordance with all applicable DHS regulations regarding resident records.

The Administrator or Designee will conduct quarterly audits during the Quality Plan review process. The Quality Plan Meeting is scheduled for 04/24/26.

Records will be kept in the by the Administrator in the Administrator's office and will be made available to the department for review. There will be a file checklist in each file for the Administrator or designee to sign off and acknowledge completeness. The check list will begin for all new admissions starting on 3-17-2026. A secondary, (double check) will be completed within 4 hours of the admission all new admissions, by Administrator. Quarterly audits will begin in June. 2026. During each quarterly audit, the Administrator or designee will review admitted resident records to verify completion of all required admission documentation, including but not limited to;

Complete and Signed admission agreement including Resident rights acknowledgment by the resident.

## 41e Signed Statement (continued)

Licensee's Proposed Overall Completion Date: 04/24/2026

Implemented [REDACTED] - 05/14/2026)

## 60a - Staff/Support Plan

## 3. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

## Description of Violation

On [REDACTED], there were 34 residents present in the home, including 22 residents with mobility needs. Of the 22 residents with mobility needs, 11 of the residents require the physical assistance of 2 staff persons to transfer in/out of bed/chair. The home's most recent fire safety inspection conducted by a fire safety expert on [REDACTED] indicates the maximum evacuation time to evacuate residents to numerous fire safe areas is 8 minutes. However, on [REDACTED] from approximately 11:00pm through approximately 7:00am on 3/8/26, there were only 2 staff persons present in the home, which is not adequate to evacuate all residents in the event of an emergency.

## Plan of Correction

Accept [REDACTED] - 04/23/2026)

Effective immediately, on 03/10/26 the facility adjusted overnight staffing to ensure sufficient numbers of staff are scheduled to meet resident care needs and emergency evacuation requirements, including the needs of residents requiring two person assistance.

On March 11, 2026, the Administrator provided education to the Director of Wellness (DOW) and Assistant Director of Wellness (ADOW) regarding compliance with 55 Pa. Code §2600.60(a). Education included required staffing levels based on resident acuity, evacuation capability within the approved fire safety time, and accountability for safe scheduling on all shifts.

Moving forward, the Administrator along with the DOW and ADOW is responsible for ensuring staffing schedules reflect current resident acuity and evacuation needs, including the number of residents requiring two staff assistance.

As of 03/11/26 the Administrator, Wellness Director and Assistant Wellness Director, will conduct weekly staffing and schedule meetings to verify compliance with staffing requirements and ensure adequate coverage on all shifts. Any identified deficiencies will be corrected immediately and documented and kept in Administrators office for DHS inspection. If calls offs occur that affect the current staffing schedule the Director or Wellness or Assistant Director of Wellness will be required to secure immediate coverage up to including one of them to be on call to cover the shift, Additionally, the Executive Director must be notified immediately of any occurrences that may affect adequate coverage. The Executive Director, will also be required to cover any shifts if the the ADOW or DOW are not available and no other coverage can be found.

The Wellness Director and Assistant Wellness Director will be responsible for preparing and reviewing staff schedules, participating in weekly staffing meetings, to identifying coverage gaps, and immediately reporting and correcting any staffing deficiencies.

**60a Staff/Support Plan (continued)**

Staffing levels adjusted to ensure (3) three, staff will be on duty during the 11pm to 7am shift. If a call off occurs and no replacement is found, ADOW, DOW and/or Administrator will fill the vacancy.

Proposed Overall Completion Date: 04/22/2026

Licensee's Proposed Overall Completion Date: 04/22/2026

Implemented (████) - 05/14/2026)

**65a - FS Orientation 1st Day**

**4. Requirements**

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

**Description of Violation**

Direct care staff person A, hired on ██████████, did not receive orientation on any of the topics specified in 2600.65a.

**Plan of Correction**

Accept ██████████ - 04/23/2026)

On March 12, 2026, the facility revised its Orientation Training Packet and course curriculum to ensure full compliance with the requirements outlined in DHS regulation 55 Pa. Code §2600.65(a) and §2600.65(b). The updated curriculum incorporates all mandated training components, including evacuation procedures; staff duties and responsibilities during drills and emergencies; designated meeting locations during fire emergencies; smoking safety and the facility's smoking policy; the location and proper use of fire extinguishers; the function and monitoring of smoke detectors and fire alarm systems; and emergency communication procedures. Following these updates, all current staff were re oriented by the Administrator and Director of Wellness using the revised curriculum, and completion of this training was documented with signatures from both the employee and the Director of Wellness (DOW) and/or Administrator no later than March 16, 2026.

On April 7, 2026, Fire Safety Expert ██████████ conducted the facility's annual fire safety training for all staff. This training included a comprehensive review of fire prevention and emergency response procedures, followed by a fire drill during which all residents were safely evacuated to a designated fire safe area. Documentation of both the revised orientation curriculum and the completed fire safety training, including drill records, has been maintained in the staff training binder located in the Administrator's office and is readily available for DHS inspection.

Effective March 12, 2026, a formalized policy and procedure was implemented to ensure ongoing compliance with orientation requirements. At the conclusion of each new hire's orientation, the Administrator is responsible for

**65a - FS Orientation 1st Day (continued)**

reviewing the employee's training record to confirm that all required components have been completed in full prior to the employee being permitted to proceed with on-the-job training. On March 12, 2026, the Administrator also met with all Department Heads involved in the orientation process to provide education on the revised procedures. Department Heads were instructed on their responsibilities in onboarding, including the facilitation of assigned training topics and the requirement that all training be delivered comprehensively and documented with signatures from both the trainer and the employee. This enhanced process ensures accountability and consistency in the delivery and documentation of required training for all staff moving forward.

Staff person #A received training covering 2600.65a & b, with a signed training document placed in [REDACTED] file on 03/10/26. Administrator will keep the records in the office for DHS inspection.

The administrator/designee shall review all new hire staff records monthly for the next 6 months beginning April 22, 2026 to ensure all newly hired staff persons receive orientation on all topics specified in 2600.65a prior to or during the first workday and that documentation of the orientation is present in the staff person's record.

Proposed Overall Completion Date: 04/22/2026

Licensee's Proposed Overall Completion Date: 04/22/2026

Implemented ([REDACTED] - 05/14/2026)

**65b - Rights/Abuse 40 Hours****5. Requirements**

2600.

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

4. Reporting of reportable incidents and conditions.

**Description of Violation**

Direct care staff person A, hired on [REDACTED], completed [REDACTED] 40th scheduled work hour; however, did not receive orientation on reporting of reportable incidents and conditions.

**Plan of Correction**

Accept ([REDACTED] - 04/23/2026)

Staff person A was removed from the floor schedule on March 9, 2026 until a completed education on residents rights was facilitated and acknowledged. Direct Care Staff Person A was provided education on the reporting of reportable incidents and conditions in accordance with § 2600.65(b) on March 10, 2026. This Documentation was kept for staff person A.

Also, on 03/10/26, the administrator reviewed orientation requirements to ensure all mandatory topics are included and documented appropriately for staff person A.

On March 11, 2026, the Administrator created and implemented a new orientation form and orientation packet that clearly includes training on reporting reportable incidents and conditions was developed. The new orientation form was implemented and placed into active use beginning March 11, 2026.

On 03/12/26 the Administrator re-educated all department heads that participate in orientation on the content that is required in the orientation process, how to complete the paperwork to ensure the employee acknowledges as

**65b - Rights/Abuse 40 Hours (continued)**

well as the respective trainer and requirements of regulation 2600.65a and 2600.65b. As of 03/12/26 the facility also implemented a new policy and procedure that requires the Administrator to check a new hire file prior to scheduling on the job training to ensure that all required orientation topics were completed under 2600.65a and 2600.65b. The Department Heads participating in training of resident's rights as well as the Administrator will be responsible for ensuring compliance.

The administrator/designee shall review all new hire staff records monthly for the next 6 months, beginning April 24, 2026, to ensure all newly hired staff persons receive orientation on all topics specified in 2600.65b within 40 scheduled working hours and that documentation of the orientation is present in the staff person's record. Documentation of training for Staff person A, will be kept in Administrators office for DHS inspection.

**Licensee's Proposed Overall Completion Date:** 04/22/2026

**Implemented** [REDACTED] - 05/14/2026)

**65g - Annual Training Content**

**6. Requirements**

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

**Description of Violation**

Direct care staff person B, hired on [REDACTED], did not receive annual training on fire safety completed by a fire safety expert or by a staff trained by a fire safety expert during the 2025 training year.

REPEAT VIOLATION: [REDACTED] et. al.

**Plan of Correction**

**Accept** [REDACTED] - 04/23/2026)

On 03/09/26 Staff Person B was immediately removed from the schedule and was not permitted to work until Fire Safety Training was completed. Staff Person B successfully completed Fire Safety Training on March 10, 2026, and documentation was added to the personnel file.

A complete Employee File Audit was completed on 3-16-2026 by the Administrator. Additionally, the Administrator will be responsible to conduct a quarterly audit of employee training files will be conducted to ensure compliance with § 2600.65 requirements beginning in June of 2026. On 04/07/26 the Administrator started a tracking system to ensure annual training is completed by all staff in accordance with 2600.65g.

The Administrator will maintain oversight and ensure corrective actions are taken immediately if deficiencies are found.

Records will be kept in Administrator's office for DHS inspection.

On March 12, 2026 the Administrator completed training to the Director of Wellness, Assistant Director of Wellness

**65g - Annual Training Content (continued)**

and the Maintenance coordinator on 2600.65g as they are also involved in facilitating and tracking annual fire safety training.

April 7, 2026, Annual Fire Safety Training by Fire Safety Expert, [REDACTED] was completed for all staff, and a fire drill was conducted, all residents evacuated to a fire safe area. Moving Forward the Administrator or designee will be responsible for ensuring the completion of all annual training of employees.

Quarterly audits will be conducted by Administrator and/or Designee beginning in June 2026.

Licensee's Proposed Overall Completion Date: 04/22/2026

Implemented [REDACTED] - 05/14/2026)

**85a - Sanitary Conditions****7. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

**Description of Violation**

On [REDACTED] at 10:25am, there were no paper towels, hand dryer or other sanitary means to dry hands present in the shared bathroom for residents [REDACTED] and [REDACTED]

REPEAT VIOLATION: [REDACTED] et. al.

**Plan of Correction**

Accept [REDACTED] - 04/14/2026)

The housekeeping department corrected immediately on March 9,2026 while inspectors on site. Paper towels and/or towels were replenished by housekeeping in the two affected resident rooms on the same day the deficiency was identified.

Beginning March 10,2026, The Administrator implemented a Daily Housekeeping Audit Checklist to verify that all resident rooms and bathrooms are supplied with required hygiene items, including paper towels, towels, soap, and toilet tissue, and that these items are filled and functioning properly. Education was provided to the housekeepers on 03/10/26 to ensure understanding of this requirement and to ensure ongoing compliance.

Beginning on 03/11/26, the checklist is compiled and reviewed weekly by the Administrator or designee. Any noted issues must be reported immediately to Administrator and/or Maintenance for prompt corrective action.

As of March 16, 2026, Weekly housekeeping random audits will be done by Administrator or Operations Support Assistant, and log reviewed weekly by Administrator. Administrator will conduct quarterly room inspections.

## 85a Sanitary Conditions (continued)

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

Implemented (■■■■ - 05/14/2026)

## 89b - Hot Water Temperature

**8. Requirements**

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

**Description of Violation**

On ■■■■ at 10:30am, the hot water temperature at the shared bathroom sink for residents ■■■■ and ■■■■ was 125.4 degrees Fahrenheit.

On ■■■■ at 10:40am, the hot water temperature at resident ■■■■ bathroom sink was 122.1 degrees Fahrenheit.

On ■■■■ at 10:53am, the hot water temperature at ■■■■ bathroom sink was 124.2 degrees Fahrenheit.

89b - Hot Water Temperature (continued)

Plan of Correction

Accept [REDACTED] - 04/23/2026)

Immediately on 03/19/26 the Maintenance Coordinator adjusted the mixing valves in the affected rooms. Water temperatures in all 4 rooms were re-tested and brought back into DHS compliance. From March 11, 2026, through April 10, 2026, Maintenance will check 10 randomly selected resident rooms per weekday for hot water temperature compliance. Temperatures will be logged on a tracking sheet, and any out-of-range readings will be corrected immediately and re-tested. This record will be kept in the Administrators office. On March 13, 2026, the Administrator re-educated the Maintenance Coordinator on DHS hot water temperature requirements and proper adjustment procedures. Training included documentation expectations and reporting of out-of-range readings to the Administrator. A record maintenance directors re-education will be kept in [REDACTED] employee record which is kept in the Administrators office. As an ongoing safety and compliance measure the Maintenance Coordinator will be responsible to check the water temps of all resident rooms on a quarterly basis. [REDACTED] will be required to supply [REDACTED] log to the Administrator for review and will be required to address any temperature adjustments needed immediately upon discovery.

After initial 30-day checks, Maintenance Director and/or designated staff person shall test hot water temperatures from at least 3 different sources accessible to residents each week to ensure long-term compliance with 2600.89b. Documentation of the weekly checks shall be kept. This will be implemented the week of April 13, 2026. The day of week may vary week to week but will be done weekly.

Proposed Overall Completion Date: 04/22/2026

Licensee's Proposed Overall Completion Date: 04/22/2026

Implemented [REDACTED] - 05/14/2026)

100a - Exterior - Free of Hazards

9. Requirements

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On [REDACTED] at approximately 10:00am, the particle board ramp leading into the exit door into the resident lounge was in disrepair and had 3 footprint-size divots present on the particle board.

Plan of Correction

Accept [REDACTED] - 04/14/2026)

The deficient particle board on the ramp was immediately removed and replaced with new, appropriate material by the Maintenance Department before inspectors left the facility on March 10, 2026.

At the time of replacement, the ramp was inspected to ensure:

The surface was level and secure

No remaining divots or hazards were present

The issue was fully corrected, and no residents were harmed.

A full monthly property and structural inspection audit was implemented beginning March 10, 2026 by the Administrator and the Maintenance Coordinator. Inspections include ramps, walkways, flooring, and other high-traffic and safety-sensitive areas.

*100a - Exterior - Free of Hazards (continued)*

*The Administrator and/or Maintenance Department is responsible for completing inspections and initiating repairs promptly.*

*As of March 10, 2026 the Administrator will review and sign off on each monthly inspection to ensure findings are addressed in a timely manner. The administrator will do Quarterly property inspections to ensure compliance. All inspections and corrective actions will be documented and maintained on-site for DHS review. Records will include date of inspection, findings, corrective actions taken, and completion dates. Records will be kept in Administrators office for DHS review.*

*The Maintenance Coordinator and the Administrator will be responsible for ongoing compliance.*

## 100a Exterior Free of Hazards (continued)

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

Implemented [REDACTED] - 05/14/2026)

## 101j7 - Lighting/Operable Lamp

## 10. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

## Description of Violation

On [REDACTED] at 10:17am, resident [REDACTED]'s bedside lamp was approximately 6 feet from the resident's bed and could not be turned on/off from bedside.

REPEAT VIOLATION: [REDACTED], et. al.

## Plan of Correction

Accept [REDACTED] - 04/23/2026)

On March 9, 2026, upon identification of the concern, the Administrator immediately relocated the lamp to the resident's bedside to ensure it was within arm's reach and readily accessible. Following relocation, the resident was able to independently access the lighting.

To prevent recurrence, the facility implemented corrective measures, including the purchase and installation of touch activated bedside lamps in affected resident rooms to promote ease of use, immediate accessibility, and provide an additional light source.

On March 12, 2026, the Administrator provided education to Housekeeping, Wellness staff, Director of Wellness (DOW), Assistant Director of Wellness (ADOW), and the Admissions Director regarding resident room safety and lighting requirements. Training emphasized the importance of bedside access to lighting for resident safety and independence, reinforced facility policies related to environmental safety and resident accommodations, and clarified staff responsibility to immediately report and correct environmental concerns. All applicable staff completed this education.

**101j7 - Lighting/Operable Lamp (continued)**

Effective March 10, 2026, daily housekeeping and environmental audits were initiated by the Administrator to include verification that a functional lamp is present and properly positioned at each resident's bedside. Beginning March 16, 2026, random joint housekeeping and environmental audits are conducted by the Operations Support Assistant, documented, and reviewed monthly by the Administrator. Audit results confirmed that resident rooms are equipped with functioning bedside lamps positioned within reach, and that touch-activated lamps are installed and operational as needed. Based on these findings, the facility is in compliance with bedside lighting requirements, with no further deficiencies identified.

Housekeeping staff are responsible for ensuring all lamps are properly placed at the bedside. The Operations Support Assistant is responsible for conducting weekly random audits, including verification of bedside lamp placement. The Administrator is responsible for staff education, oversight of environmental monitoring, implementation of corrective actions, and ensuring ongoing compliance with lighting and resident room safety requirements.

All audit documentation is maintained on-site in the Administrator's office and is available to the Pennsylvania Department of Human Services upon request.

The random, weekly audits completed by Administrator beginning 3-13-2026, and moving forward to be completed by the Operations Support Assistant, beginning 4-6-2026. Weekly Audits will be done on 5 rooms per each of the three communities' hallways (3) to total 15 rooms weekly.

Licensee's Proposed Overall Completion Date: 04/22/2026

Implemented [REDACTED] - 05/14/2026)

**103f - Refrigerator/Freezer Temps****11. Requirements**

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

**Description of Violation**

On [REDACTED] at 10:05am, the temperature in the Hotpoint chest freezer, located in the dry storage area, was 15 degrees Fahrenheit and at 2:39pm, it was 2 degrees Fahrenheit.

REPEAT VIOLATION: [REDACTED], et. al.

**Plan of Correction**

Accept [REDACTED] - 04/23/2026)

On March 9, 2026, maintenance staff inspected the freezer immediately upon notification of a temperature variance reading of 2°F. All food items stored in the freezer were discarded at that time to ensure food safety. Upon inspection, the cause was identified as a minor equipment drift/calibration issue. Maintenance staff corrected the issue the same day through adjustment and recalibration of the unit to ensure it consistently maintains a temperature of 0°F or below. A full freezer defrost and mechanical inspection were also completed to verify proper operation. The unit returned to compliance on March 9, 2026, and all corrective actions were fully completed by March 11, 2026.

On March 12, 2026, the Administrator provided retraining to both dietary and maintenance staff. This training included instruction on proper freezer temperature standards (0°F or below), required frequency and accuracy of

**103f - Refrigerator/Freezer Temps (continued)**

temperature monitoring and documentation, and the immediate reporting protocol for any temperature irregularities. Training also reinforced compliance with §2600.103 Food Service regulations related to maintaining safe food storage conditions.

Dietary staff are responsible for completing and documenting freezer temperature logs daily and are responsible to report any temperature reading above 0°F immediately to both maintenance staff and the Administrator.

Maintenance staff are responsible for performing weekly inspections of all refrigeration equipment to verify proper calibration and functionality, and for initiating immediate corrective action if any issue is identified. If any refrigerator or freezer is found to be out of compliance or not functioning properly, all food items will be discarded, and the unit will be removed from service until it is fully repaired or replaced and verified to be operating within required temperature ranges.

The Administrator is responsible for conducting weekly audits of temperature logs for a minimum of four consecutive weeks beginning March 12, 2026, to ensure compliance with monitoring and documentation requirements. All corrective actions, training records, and ongoing monitoring documentation will be maintained in compliance files in the Administrator's office and will be made available for review upon request.

The dietary staff are currently inspecting all refrigerators/freezers daily for operable thermometers and documenting each temperature. The weekly maintenance checks began on 3-17-2026.

Proposed Overall Completion Date: 04/22/2026

Licensee's Proposed Overall Completion Date: 04/22/2026

Implemented [REDACTED] - 05/14/2026)

**103g - Storing Food**

**12. Requirements**

2600.

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

**Description of Violation**

On [REDACTED] at approximately 10:00am, there was an open and unsealed five-pound bag of Cellone's plain breadcrumbs, which was approximately 1/2 full, present on the dry storage kitchen shelf unit.

REPEAT VIOLATION: [REDACTED], et. al.

**Plan of Correction**

Accept [REDACTED] 04/23/2026)

On March 9, 2026, the improperly sealed bag of breadcrumbs was immediately removed and discarded, at the time of inspection by Administrator. A complete audit of all dry food products was performed on March 9, 2026, by the Administrator and Dining Manager to ensure every item was properly sealed, labeled, and stored according to safe dry-storage standards.

Any items found in noncompliance were corrected immediately. On 03/12/26 All dining staff were reminded that all opened dry foods must be sealed in their original resealable bag or transferred into an airtight container, as required for preventing moisture exposure and pest contamination.

103g Storing Food (continued)

Beginning March 9, 2026, weekly kitchen sanitation audits, completed by the new Dietary Manager, which will include a dedicated dry storage inspection section. The Dietary Manager will verify:  
 All opened food items are sealed airtight. No damaged or improperly stored items are present. FIFO rotation is being followed. All dry foods are stored in a cool, dry, well ventilated area as recommended (50 70°F).  
 Findings will be documented on the weekly audit log and maintained in the Dietary Compliance Binder.  
 The Dining Manager will be responsible to notify the Administrator upon identification of any noncompliance issues.  
 As of March 10, 2026, the Administrator will complete monthly inspections of kitchen and dry storage for compliance.

On 3 12 2026, dietary staff were educated on safe food storage practices; 2600.103g. Training sign in sheet will be maintained in staff education files in Administrators office for DHS inspection.

As an added measure of to secure items storage containers were purchased with airtight lids by the facility the Administrator for items that may need better packaging.

As of March 13, 2026, Dietary staff will be reminded at daily huddles about proper sealing expectations.

Any staff found not following proper storage procedures will receive immediate coaching.

The Dining Manager and Administrator will be responsible for ensuring ongoing compliance. On April 24, 2026, our quarterly quality meeting will take place. Review of 2600.26b and plan of corrections, food storage practices topics will be included.

will be included.

The Dietary Manager will review storage practices during quarterly Quality Assurance (QA) meetings.

The home maintains a Quality Management Plan that includes the periodic review and evaluation of reportable incident and condition reporting, complaint procedures, staff training, licensing violations and plans of correction, and resident or family council concerns, as applicable. Admission and resident record audits are incorporated into this process to monitor compliance with regulatory requirements and identify areas needing improvement.

Proposed Overall Completion Date: 04/24/2026

Licensee's Proposed Overall Completion Date: 04/24/2026

Implemented [REDACTED] - 05/14/2026)

132d - Evacuation

13. Requirements

2600.

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 home.

Description of Violation

The home conducted an unannounced fire drill on [REDACTED] at 12:30pm. According to the home's fire drill records, 35 residents were present in the home and that 35 residents were evacuated; however, resident [REDACTED] was not evacuated to a fire safe area during this fire drill.

REPEAT VIOLATION: [REDACTED], et. al.

132d - Evacuation (continued)

**Plan of Correction**

**Directed (█ - 04/23/2026)**

After the inspection the, on March 10, 2026, The Administrator investigated and determined that the deficiency occurred due to staff error during execution and documentation of the fire drill, as Resident █ was not evacuated to a designated fire-safe area, and final resident accountability was not verified before documentation was completed.

On March 11, 2026, the Administrator educated the Director of Wellness, Assistant Director of Wellness and the Maintenance Coordinator of this regulation to include that all residents, without exception, must be evacuated to a fire-safe area during drills unless otherwise directed by emergency authorities.

On April 7th, 2026, All Staff completed annual fire safety training with fire expert █ this training included taking roll procedures and included instruction to ensure that staff are aware that all residents must be evacuated in accordance with 2600.132d.

Additionally, resident █ will have a transport wheelchair accessible to assist in evacuations during drills or emergencies. This was added to █ care plan on 04/11/26.

The administrator shall review all fire drill documentation monthly to ensure compliance with 2600.132d and to ensure all residents evacuate during each fire drill. (DIRECTED: The administrator monthly audits shall begin on 4/27/26. █ 4/22/26).

Documentation of all staff education will be kept in accordance with 2600.65i.

55 Pa. Code § 2600.65(i) requires that documentation of all staff training and education be maintained and kept in each staff person's record in Administrators office for DHS inspection.

Proposed Overall Completion Date: 04/22/2026

Directed Completion Date: 04/22/2026

**Implemented (█ - 05/14/2026)**

132g - Fire Drills Days/Times

**14. Requirements**

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

**Description of Violation**

The home routinely conducts fire drills at the top of the hour, to include the following fire drills:

- █
- █
- █
- █
- █

132g - Fire Drills Days/Times (continued)

**Plan of Correction**

Accept [REDACTED] - 04/23/2026)

On March 10, 2026, the Administrator immediately directed all maintenance and supervisory staff that fire drills must be conducted at random, non-predictable times. This directive was implemented effective immediately. On March 13, 2026, the Maintenance Coordinator was re-educated by the Administrator on fire drill requirements, with specific emphasis on ensuring drills are scheduled at varying times of day, different days of the week, across all shifts, and in different locations within the facility. The prohibition of conducting drills at the top of the hour was reinforced. Effective March 10, 2026, the Maintenance Coordinator is responsible for developing fire drill schedules that ensure full randomization of time, day, shift, and location. The Maintenance Coordinator must consult with and obtain approval from the Administrator prior to conducting each drill to confirm compliance with these requirements. After each fire drill, the Administrator is responsible for conducting a debriefing with the Maintenance Coordinator to review the execution of the drill, including timing, staff response, and resident evacuation. The Administrator will also review the fire drill log to ensure documentation is complete, accurate, and reflects that the drill was conducted at a random time and not on the hour. The Maintenance Coordinator also completed fire safety training with a certified fire safety expert on 4-7-2026, reinforcing proper procedures for compliant and effective fire drill implementation.

The administrator reviewed all fire drill documentation beginning January 2026 and will review monthly to ensure long-term compliance beginning 3-13-2026. Fire drill procedures were reinforced right away, Oversight began right away, and continued Auditing will occur with the next drill. Documentation of audits and education will be kept in employee files in Administrators office for DHS inspection.

Proposed Overall Completion Date: 04/22/2026

Licensee's Proposed Overall Completion Date: 04/22/2026

Implemented [REDACTED] - 05/14/2026)

141a 1-10 Medical Evaluation Information

**15. Requirements**

2600.

- 141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
  - 1. A general physical examination by a physician, physician's assistant or nurse practitioner.
  - 2. Medical diagnosis including physical or mental disabilities of the resident, if any.
  - 3. Medical information pertinent to diagnosis and treatment in case of an emergency.
  - 4. Special health or dietary needs of the resident.
  - 5. Allergies.
  - 6. Immunization history.
  - 7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
  - 8. Body positioning and movement stimulation for residents, if appropriate.
  - 9. Health status.
  - 10. Mobility assessment, updated annually or at the Department's request.

**Description of Violation**

Resident [REDACTED]'s medical evaluation, dated [REDACTED] does not include resident [REDACTED] special health or dietary needs. This

**141a 1 10 Medical Evaluation Information (continued)**

section of resident # [REDACTED]'s medical evaluation is blank.

REPEAT VIOLATION: [REDACTED], et. al.

**Plan of Correction****Accept (LM - 04/23/2026)**

On March 9, 2026, immediately while inspectors on site the Director of Wellness contacted the resident's medical provider regarding the missing diet documentation to get an updated diet order. The medical provider was present in the building the same day. The provider corrected the DME form by adding the required diet order and signature. The Director of Wellness reviewed the resident's chart to ensure the diet information was accurate and consistent across all related clinical documentation.

All corrective actions were completed on March 9, 2026.

In order to ensure ongoing compliance, the Administrator identified, a formal secondary review process was not in place to confirm that required clinical fields such as diet orders were completed, signed, and consistent across all resident health documentation. As a result, the incomplete documentation was not identified until the licensing inspection. Therefore, the Administrator has implemented as of 03/13/26 a two step documentation verification process that includes Initial review by the Wellness Director and the Assistant Wellness Director for completeness and accuracy Secondary review by the Administrator/Designee

Any incomplete documentation will be returned to the medical provider for correction. This two step process will be completed on all initial, significant change or annual DME's.

On March 13, 2026, education was completed by the Administrator with the Director of Wellness (DOW), Assistant Director of Wellness (ADOW) and Admissions Director to include Review of 55 Pa. Code § 2600.141(a) requirements, Reinforcement of the requirement that all clinical documentation be complete, accurate, and signed and Verification that diet, diagnosis, mobility, allergies, and safety risks are consistent across all resident documents and Staff responsibility to identify and correct incomplete documentation prior to filing. Staff education records will be kept in the administrator's office for DHS inspection.

A full audit of each resident's record was reviewed for a complete and signed DME forms and accurate diet documentation

was completed on March 16, 2026, by the Administrator.

The Director of Wellness, Assistant Director of Wellness and/or the Administrator/Designee will be responsible for ongoing compliance.

A secondary, (double check) will be completed the next business day for all new medical evaluations for accuracy and completeness by Assistant Director of Wellness and/or Administrator.

There will be a file checklist in each file for the Administrator/ Designee to sign off and acknowledge completeness.

Proposed Overall Completion Date: 04/22/2026

Licensee's Proposed Overall Completion Date: 04/22/2026

**Implemented [REDACTED] - 05/14/2026)****191 - Resident Right to Refuse**

**16. Requirements**

2600.

191. Resident Education The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

**Description of Violation**

Resident [REDACTED] record does not contain documentation indicating resident [REDACTED] was educated on their right to question or refuse a medication if the resident believes there may be a medication error. Resident [REDACTED] was admitted to the home on [REDACTED].

REPEAT VIOLATION: [REDACTED], et. al.

**Plan of Correction**

Accept [REDACTED] - 04/23/2026)

On March 10, 2026, the Administrator reviewed all Resident Rights, including the resident's right to question or refuse medications, with Resident [REDACTED]. The resident demonstrated understanding, and a signed acknowledgment of Resident Rights was obtained and placed in the resident record. Compliance for Resident [REDACTED] has been achieved as of March 10, 2026.

By March 16, 2026, all resident files were audited by the Administrator to ensure the presence of:

A signed resident contract

Signed acknowledgment of Resident Rights

Required medical evaluation documentation

Any missing documentation identified during the audit was immediately corrected to ensure compliance with 55 Pa. Code §2600 requirements.

As of 03/11/26 an admission checklist has been reinforced to ensure all required documents are reviewed, explained, signed, and filed prior to or immediately upon admission. The Administrator will be responsible for ensuring all required documents are in the residents record prior admission that includes the completed and signed contract with the resident's rights statement and complaint procedures,

Additionally at the April 8th resident meeting the Life Enrichment Director reviewed the resident's rights with all the residents and signed acknowledgements were collected. Records of acknowledgements will be kept in the Administrators office.

On March 13, 2026, the Administrator provided re-education to the Admission Director and Director of Wellness and Assistant Director of Wellness Director, covering:

Resident contracts

Medical evaluation documentation

Resident Rights, including a resident's right to question or refuse medications

Education emphasized the importance of obtaining signatures and placing documentation in the resident's record at the time of admission.

A secondary, (double check) will be completed within 4hours for all new admissions, or changes, by Assistant Director of Wellness and/or Administrator/Designee.

The Admissions Director and Administrator will be responsible to ensure ongoing compliance by checking the

191 Resident Right to Refuse (continued)

record for an acknowledgment of resident's rights prior to resident admissions and will be required to sign a checklist in the resident record acknowledging receipt.

Proposed Overall Completion Date: 04/22/2026

Licensee's Proposed Overall Completion Date: 04/22/2026

Implemented [REDACTED] - 05/14/2026)

254a - Records Discharge/Active

17. Requirements

2600.

254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On [REDACTED] 10:20am, the laptop computer for the A Hall medication cart was unlocked, unattended and accessible with resident [REDACTED] current medication administration record (MAR) visible on the laptop screen.

Plan of Correction

Accept [REDACTED] - 04/23/2026)

On March 10, 2026, once the issue was identified, the computer was immediately secured and logged off by Administrator, to prevent any further unauthorized access to resident confidential information. The Pharmacy staff member involved was counseled immediately regarding the requirement to safeguard resident records and maintain confidentiality at all times.

A medication cart and workstation audit was conducted on all three shifts for a two week period, beginning 3 10 2026, with audits completed by Medication Technicians to ensure computers and electronic systems containing resident information were secured when not in use.

After initial two week auditing, supervisory staff will conduct weekly random and routine observations of computer and documentation practices to ensure that computers are not left unattended while logged in.

On March 12, 2026, the Director of Wellness facilitated a training to all wellness staff on HIPAA and confidentiality, including pharmacy staff, with specific emphasis on safeguarding resident information, securing computers, logging off workstations when unattended, and compliance with 55 Pa. Code §2600.254(a). Training included review of facility confidentiality policies, electronic records security, and staff responsibilities related to resident record protection. Computer systems have been reviewed, and logging off is mandatory, when not present at cart. Any future violations will be addressed through progressive disciplinary action per facility policy. Documentation of staff education will be kept in employee files in the Administrator's office for DHS inspection.

The Director of Wellness/Assistant Director of Wellness are responsible for monitoring and audits. The Administrator is responsible for ensuring implementation, staff education, monitoring, and ongoing compliance with confidentiality requirements and corrective actions. Audits will be held in Administrators office for DHS inspection.

Proposed Overall Completion Date: 04/22/2026

Licensee's Proposed Overall Completion Date: 04/22/2026

Implemented [REDACTED] - 05/14/2026)