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

May 1, 2026

[redacted]
JUNIPER VILLAGE AT MONROEVILLE LLC
[redacted]

RE: JUNIPER VILLAGE AT MONROEVILLE
2589 MOSSIDE BOULEVARD
MONROEVILLE, PA, 15146
LICENSE/COC#: 45263

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/26/2026, 03/30/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *JUNIPER VILLAGE AT MONROEVILLE* **License #**: *45263* **License Expiration**: *12/08/2026*

Address: *2589 MOSSIDE BOULEVARD, MONROEVILLE, PA 15146*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *JUNIPER VILLAGE AT MONROEVILLE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *98* **Waking Staff**: *74*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *03/30/2026*

Inspection Dates and Department Representative

03/26/2026 On Site: [redacted]

03/30/2026 On Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *126* **Residents Served**: *65*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *1st Floor* **Capacity**: *21* **Residents Served**: *16*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *65*

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

Have Mobility Need: *33* **Have Physical Disability**: *0*

Inspections / Reviews

03/26/2026 - Partial

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

Inspections / Reviews *(continued)*

04/15/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/29/2026*
Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *04/21/2026*

04/21/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/29/2026*
Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/01/2026*

04/21/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/29/2026*
Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/01/2026*

04/28/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/29/2026*
Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/05/2026*

05/01/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/29/2026*
Reviewer: [redacted] **Follow Up Type:** *Not Required*

42b - Abuse

1. Requirements

2600.
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

On [redacted] at approximately 5:30pm, resident [redacted] reported to staff persons that resident [redacted] entered the bedroom of resident [redacted] got into resident [redacted]s bed and used their hands to touch resident [redacted]s breasts and pubic area over resident [redacted]s clothing. A few minutes later, resident [redacted] reported to staff persons that resident [redacted] entered resident [redacted]s bedroom and exposed their [redacted] and began [redacted] in front of resident [redacted]

Plan of Correction ***Directed ([redacted] - 04/21/2026)***

The facility strongly disagrees with this citation and formally appeals, requesting its removal in full. This was a self-reported, isolated resident-to-resident incident to which the facility responded immediately, appropriately, and in full compliance with all regulatory requirements. On 03/17/2026 at approximately 1830, Resident [redacted] reported an allegation, at which time Resident [redacted] was immediately identified, removed from the area, and placed under direct staff supervision. The Executive Director and Wellness Director were promptly notified, and an investigation was initiated without delay, including interviews with other residents, during which Resident [redacted] reported a separate observation involving Resident [redacted] No additional residents were impacted or identified. Immediate protective measures were implemented, including relocating Resident [redacted] away from others and assigning one-to-one supervision. The resident's family was notified, and, in the absence of any prior similar behavior, Resident [redacted] was transported for emergency medical evaluation and subsequently admitted with diagnoses including altered mental status and anemia, supporting a clinical basis for the behavior. Concurrently, the wellness team assessed Residents [redacted] and [redacted] confirming both were at baseline with no injuries, trauma, or complaints, and their families were notified. Preventative checks were completed on other residents, confirming no additional concerns. The facility made all required notifications, including to law enforcement, Adult Protective Services, DHS, and DOH; law enforcement conducted an investigation and filed a report, and APS completed an independent investigation prior to DHS involvement, both finding no evidence of abuse, neglect, or facility wrongdoing. The citation under 55 Pa. Code §2600.42(b) is not supported by the facts or the governing regulatory framework as interpreted by the Pennsylvania Personal Care Home Regulatory Compliance Guide, which require a showing of facility failure—not merely the occurrence of a resident-to-resident incident—to sustain a deficiency. There is no evidence the facility knew or should have known of a foreseeable risk and failed to reasonably assess, care plan, supervise, or intervene; no such evidence exists here. There is no documented history indicating Resident [redacted] posed a foreseeable risk requiring heightened supervision under §§2600.122, 2600.123, or 2600.131, nor any evidence of inadequate staffing or supervision. The RCG does not impose a strict liability standard and recognizes that not all resident behaviors are preventable. To the contrary, the facility's immediate and comprehensive response—including prompt identification and separation of the resident, implementation of one-to-one supervision, immediate investigation, clinical assessment of all involved residents, hospital transfer, and timely notification of all required authorities in accordance with §2600.16—demonstrates full compliance with regulatory expectations. Because the RCG further provides that resident-to-resident conduct does not constitute a violation absent a demonstrated failure in assessment, care planning, supervision, or intervention, and no such failure is present, the record supports that the facility acted appropriately and in full compliance. Accordingly, the citation should be dismissed in its entirety.

The following plan of correction is provided for compliance purposes only and is not admission of any wrongdoing

42b Abuse (continued)

by the facility:
Resident # 1was immediately removed from interactions with residents and was assigned a 1:1 and was subsequently sent to the hospital for evaluation.
Resident [redacted] was not admitted back to the community due to posing immediate harm to other residents and was discharged as required by regulatory requirements.
Staff were provided education on identifying abuse and resident rights and reporting requirements. Completed on 3/19/2026. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 4/21/26).
ED and DOW reviewed and verified no other resident behaviors have been exhibited or reported from other residents Any reported or witnessed incident of alleged resident assault will be reported for team to take required protective actions including care planning change, increased supervision or discharge.
Monthly review of quality practice for identified incidents/assaults by ED/DOW or designee for follow up as needed. (DIRECTED: The monthly reviews shall begin on 4/24/26. [redacted] 4/21/26).
When observed, potentially harmful behaviors are reported to the DOW or designee for behavioral prorgress note or behavioral tracking when indicated. Behaviors may include agitation, hallucinations, wandering, verbal abuse, or social withdrawal, focusing on the specific behavior, trigger, and intervention. New behaviors will be reviewed at the morning leadership meeting identified incidents/assaults will be reviewed by ED/DOW or designee for follow up as needed and reviewed at monthly quality review meeting. (DIRECTED: Beginning on 4/24/26: The administrator/designee shall review all behavior documentation at least weekly s and provide appropriate interventions to ensure residents are free from abuse. [redacted] 4/21/26)

DIRECTED: By 5/1/26: The home shall conduct a quality management review, which includes a review of all items specified in 2600.26b. Documentation of the review shall be kept. [redacted] 4/21/26

Proposed Overall Completion Date: 04/20/2026

Directed Completion Date: *05/01/2026*

Implemented [redacted] - 05/01/2026)

228b - Discharge or Transfer

2. Requirements

2600.
228.b. If the home initiates a discharge or transfer of a resident, or if the legal entity chooses to close the home, the home shall provide a 30-day advance written notice to the resident, the resident's designated person and the referral agent citing the reasons for the discharge or transfer. This shall be stipulated in the resident-home contract. A 30-day advance written notice is not required if a delay in discharge or transfer would jeopardize the health, safety or well-being of the resident or others in the home, as certified by a physician or the Department. This may occur when the resident needs psychiatric or long-term care or is abused in the home, or the Department initiates closure of the home.

Description of Violation

On [redacted] the home discharged resident [redacted] however, the home did not provide a 30 day advance written notice to resident [redacted] or resident [redacted] s designated person.

Plan of Correction ***Directed [redacted] - 04/21/2026)***

The facility respectfully disagrees with and appeals the citation related to the alleged failure to provide a 30 day notice of discharge and asserts that its actions were fully compliant with 55 Pa. Code §2600.228, which expressly permits transfer or discharge without 30 days' notice when the safety of the resident or other individuals in the

228b Discharge or Transfer (continued)

home is at risk or when the facility cannot meet the resident's needs. In this case, following a serious and unprecedented behavioral incident involving sexually disinhibited and intrusive conduct toward other residents, Resident [redacted] was transferred to the hospital for evaluation and was subsequently diagnosed with altered mental status, confirming an acute and clinically significant change in condition. Based on the information and the nature of the behavior, the facility reasonably determined that it could no longer ensure the safety of other residents or adequately meet Resident [redacted]s needs within the personal care home setting. The RCG explicitly recognizes that facilities are not required to retain a resident where doing so would pose a risk to others or exceed the home's licensed capabilities, and further provides that emergency transfers or discharges may occur without advance notice under such circumstances. The facility contract expressly states a resident may be subject to move out if the resident is a danger to himself/herself or others The facility's decision was therefore not only permissible but required to uphold its duty to protect all residents under §2600.42 and related provisions governing supervision and care. Moreover, the absence of any prior history of such behavior underscores that this was an acute and unforeseeable change in condition, further justifying immediate action rather than a delayed discharge process. The facility acted in good faith, based on clinical judgment and resident safety, and in alignment with both the letter and intent of the regulation and RCG guidance.

This corrective plan is submitted solely to ensure compliance and does not constitute an acknowledgment of any wrongdoing by the facility whatsoever:
Resident [redacted] son (POA) was informed that the facility would not be accepting re admission and would be discharging the resident for safety reasons.
ED reviewed YTD discharges and confirmed all had received thirty (30) day notice as required.
ED or designee will provide thirty (30) day notice for any future discharge and will verify compliance at time of decision for discharge as well as monthly in quality review.
When the facility initiates a discharge or transfer of a resident out of the facility, the administrator shall give a 30 day advance written notice to the resident, the resident's designated person and the referral agent citing the reasons for the discharge or transfer. A 30 day advance written notice, however, is not required if a delay in discharge or transfer would jeopardize the health, safety or well being of the resident or others in the home, as directed or notified by physician order, licensed practitioner or the Department.

DIRECTED: Beginning on 4/24/26: Prior to discharging any resident from the home, the administrator shall review the discharge with their supervisor prior to issuance to ensure appropriate grounds for discharge are present in accordance with 2600.228h. If it is determined the resident discharge is appropriate, the review shall also include ensuring a written 30 day notice is issued prior to discharge specifying the reason for discharge in accordance with 2600.228b. If it is determined the delay in discharge would jeopardize the health, safety and well being of the resident or others in the home, the home shall ensure they have written documentation from the physician or the Department prior to the discharge indicating the delay in discharge or transfer would jeopardize the health, safety or well being of the resident or others in the home. All documentation regarding resident discharges shall be kept in each resident's record. [redacted] 4/21/26

Discharges shall be reviewed at leadership morning meeting to ensure the 30 day notice was initiated, and an audit will be completed at monthly quality review meeting (DIRECTED: By 5/1/26: The home shall conduct a quality management review, which includes a review of all items specified in 2600.26b. Documentation of the review shall

228b - Discharge or Transfer (continued)

be kept[redacted] 4/21/26).

Proposed Overall Completion Date: 04/20/2026

Directed Completion Date: *05/01/2026*

Implemented[redacted] - 05/01/2026)