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

May 4, 2026

[redacted]
GROVE MANOR
[redacted]

RE: WOODCREST SENIOR LIVING COMMUNITY
1 WOODCREST CIRCLE
SCOTTDALE, PA, 15683
LICENSE/COC#: 44212

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/31/2026 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: *WOODCRESTSENIOR LIVING COMMUNITY* **License #**: *44212* **License Expiration**: *11/03/2026*

Address: *1 WOODCREST CIRCLE, SCOTTDALE, PA 15683*

County: *WESTMORELAND* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *GROVE MANOR*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *12/30/2019* **Issued By**: *l&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *57* **Waking Staff**: *43*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *12/31/2026*

Inspection Dates and Department Representative

03/31/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *55* **Residents Served**: *53*

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**: *53*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *4* **Have Physical Disability**: *1*

Inspections / Reviews

03/31/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/21/2026*

04/24/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/30/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/10/2026*

Inspections / Reviews *(continued)*

05/04/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/30/2026*

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

29a SOPb1 Hospice Care: Doctor Certification

1. Requirements

2600.

29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

1. A physician, who is not an employee or contractor of the home, has certified in writing that the resident is actively dying and may suffer bodily injury or a hastened death as a result of participation in a fire drill.

Description of Violation

On [redacted] 41 residents were present in the home. During the fire drill on [redacted] at 10:05 am., only 40 residents evacuated. Hospice resident [redacted] did not evacuate during this time due to not feeling well. The home did not provide documentation from a physician the resident was actively dying and may suffer bodily injury or hastened death as a result of participation in a fire drill.

Plan of Correction ***Accept[redacted] - 04/24/2026)***

2600.29(a)(b1)

Immediate Response:

- *On 4/10/2026, the Executive Director (ED) notified Hospice Agency Medical Director of Resident [redacted] non-participation in the community's fire drill held on 10/29/2026 due to decline in health and the need for a written order for Resident [redacted] inability to participate in future fire drills due to decline in health, actively dying. Order received on 4/14/26 (see attached)*
- *On 4/13/2026 the Executive Director, LPN completed an assessment of all hospice residents residing in the home and determined all are physically capable of participating in future fire drills,*

Corrective Action:

- *On 4/14/2026, the Executive Director re-educated all staff of the homes EOP/ fire safety plans and the requirements set forth within regulation 2600.29(a)(b1). Documentation on this training is attached and will be retained within the community.*
- *On 4/15/2026 a letter was sent to all Residents, Family Members, and Responsible Parties providing a reminder of guidelines for multiple regulations including 2600.29(a)(b1). Documentation of this letter is attached and will be retained within the community.*

Preventative Action:

- *The Executive Director will conduct an audit of the homes fire drill log monthly for 6 months to verify compliance of regulation 2600.29(a)(b1)*
- *The Executive Director or Designee will complete an assessment of hospice residents immediately upon their decline in health/ terminal diagnosis and will request certified documentation from MD. All staff will then be educated regarding protocol for non-participating residents during a fire drill. DME and RASP will be updated accordingly.*
- *Findings of the assessments will be discussed monthly at the QA meeting with continuing ongoing assessments as needed. Documentation will be retained within the community.*

(supporting documentation is attached)

Licensee's Proposed Overall Completion Date: *10/30/2026*

Implemented[redacted] 05/04/2026)

82a - Poisonous Materials

2. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

At approximately 11:40 a.m., there were two plastic spray bottles approximately 4/5/ full of clear unidentified liquid in the sink cabinet in the kitchenette located in the home's chapel area.

Plan of Correction ***Accept [redacted] - 04/24/2026)***

2600.82(a)

Immediate Response:

- *The two unlabeled spray bottles were immediately removed from the kitchenette during inspection and disposed of by the maintenance supervisor.*

Corrective Action:

- *A full audit of the home was performed on 4/1/26 by the ED, Maintenance Supervisor and Housekeeping Supervisor to remove any unlabeled or unsecured poisonous materials and no further violations of 2600.85d were identified.*
- *On 4/13/2026, the Executive Director re-educated all current staff, including Housekeeping and Maintenance, on the homes policy of proper storage and labeling for poisonous materials and the requirements set forth within regulation 2600.82a. Documentation of this training is attached and will be retained within the community.*

Preventative Action:

- *Starting on 4/15/26 an audit of all cleaning supplies/ poisonous materials labeling will be conducted by Housekeeping Supervisor or Designee to verify compliance with regulation 2600.82a weekly for 4 weeks, biweekly for 4 weeks, then monthly for 2 months.*
- *Findings of these audits will be discussed monthly at the QA meeting. The QA committee will determine whether continued auditing or other interventions are necessary to achieve and maintain compliance. Documentation will be retained within the community.*

(supporting documentation is attached)

Licensee's Proposed Overall Completion Date: *08/12/2026*

Implemented [redacted] - 05/04/2026)

85d Trash Receptacles

3. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At approximately 11:34 a.m., there was a 40-gallo grey Rubbermaid garbage can next to the stove located in the home's main kitchen.

Plan of Correction ***Accept [redacted] - 04/24/2026)***

2600.85(d)

In response to violation 2600.85d, at approximately 11am on 3/31/26, the dietary cook removed the garbage

85d - Trash Receptacles (continued)

can lid and placed it next to the can while [redacted] was prepping for lunch to be served at 12pm.

Immediate Response:

- *Immediately upon identification the garbage can was covered with its lid, which was sitting next to the can, by the maintenance supervisor.*

Corrective Action:

- *On 4/1/2026, an audit of all trash receptacles in the community was completed by the Maintenance Supervisor and Housekeeping Supervisor and no further violations of 2600.85d were identified.*
- *On 4/13/2026, Executive Director re-educated current staff, including housekeeping and maintenance on the homes policy and requirements set within regulation 2600.85d. Documentation of this training will be retained within the community.*

Preventative Action:

- *Starting on 4/15/26 the Maintenance Supervisor or designee will conduct an audit of all trash cans to verify they are covered with a lid weekly for 4 weeks, biweekly for 4 weeks, then monthly for 2 months to ensure compliance with regulation 2600.85d.*
- *Findings of these audits will be discussed monthly at the QA meeting. The QA committee will determine whether continued auditing or other interventions are necessary to achieve and maintain compliance. Documentation will be retained within the community.*

(supporting documentation attached)

Licensee's Proposed Overall Completion Date: *08/12/2026*

Implemented ([redacted] - 05/04/2026)

103e - Left Overs

5. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

At approximately 11:36 a.m., there was an undated clear plastic bag of leftover cookie dough in the walk-in freezer located in home's main kitchen.

Plan of Correction ***Accept ([redacted] - 04/24/2026)***

2600.103(e)

Immediate Response:

- *On 3/31/26, Immediately upon identification, the bag of cookie dough was properly labeled and dated by Dietary Aide to comply with regulation 2600.103e.*

Corrective Action:

- *On 4/1/2026, the Dietary Supervisor conducted a full audit of the homes freezers to verify compliance of regulation 2600.103e and no further violations were identified.*
- *On 4/13/2026, the Executive Director re-educated all Dietary staff, including the Dietary Supervisor of the homes kitchen policy for labeling and dating leftovers and the requirements set forth within regulation 2600.103e. Documentation of this training is attached and will be retained within the community.*

103e - Left Overs (continued)

Preventative Action:

- *An audit of the homes freezers was created and implemented on 4/20/26 for the Dietary Supervisor or Designee to complete once a week for 3 months to verify compliance of regulation 2600.103e. Documentation on this training is attached and will be retained within the community.*
- *Findings of these audits will be discussed monthly at the QA meeting. The QA committee will determine whether continued auditing or other interventions are necessary to achieve and maintain compliance. Documentation will be retained within the community.*

(supporting documentation attached)

Licensee's Proposed Overall Completion Date: *07/20/2026*

Implemented [redacted] 05/04/2026)

132g - Fire Drills Days/Times

6. 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's staff schedule indicates the home routinely schedule 2 staff persons on the 11:00 p.m., through 7:00 a.m., shift. However, the home has not conducted a firedrill during sleeping hours with the minimum number (2) of staffing.

Plan of Correction ***Accept [redacted] - 04/24/2026)***

2600.132(g)

Immediate Response:

- *On 3/31/2026, the Executive Director (ED) Immediately reviewed the fire drill log for 2025/2026 to identify shifts where minimal staffing occurred, but a drill was not held.*
- *On 4/1/2026 the Maintenance Supervisor was re-educated on regulation 2600.132g and 2600.132h with emphasis that drills must be held on varying days/times, including shifts with minimal staffing by the ED, documentation is attached.*

Corrective Action:

- *On 4/10/2026, the Maintenance Supervisor conducted a supplemental fire drill at 3:00am, during sleeping hours with minimal staff of 2, documentation of drill is attached.*
- *On 4/13/2026, the Executive Director re-educated all staff of the homes EOP/ fire safety plans and the requirements set forth within regulations 2600.132g. Documentation of this training is attached and will be retained within the community.*

Preventative Action:

- *The Executive Director will conduct an audit of the homes fire drill log monthly for 6 months to verify compliance of regulation 2600.132g.*
- *Findings of these audits will be discussed monthly at the QA meeting. The QA committee will determine whether continued auditing or other interventions are necessary to achieve and maintain compliance. Documentation will be retained within the community.*

(supporting documentation is attached)

Licensee's Proposed Overall Completion Date: *10/30/2026*

132g - Fire Drills Days/Times *(continued)*

Implemented (- 05/04/2026)

132h - Designated Meeting Place

7. Requirements

2600.
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

On at 10:05 am., 41 residents were present in the home. However, only 40 residents evacuated.

Plan of Correction ***Accept 04/24/2026)***

2600.132(h)

Immediate Response:

- *On 3/31/2026, the Executive Director (ED) Immediately reviewed the fire drill log for 2025/2026 to ensure that all residents participated and evacuated to the designated fire-safe area, no further violations were identified.*
- *On 4/1/2026 the Maintenance Supervisor was re-educated on regulation 2600.132h by the ED, documentation of education is attached.*

Corrective Action:

- *On 4/10/2026, the Maintenance Supervisor conducted a supplemental fire drill at 3:00am ensuring participation and evacuation of all residents in the home, documentation of drill is attached.*
- *On 4/13/2026, the Executive Director re-educated all staff of the homes EOP/ fire safety plans and the requirements set forth within regulation 2600.132h. Documentation of this training is attached and will be retained within the community.*

Preventative Action:

- *The Executive Director will conduct an audit of the homes fire drill log monthly for 6 months to verify compliance of regulation 2600.132h.*
- *Findings of these audits will be discussed monthly at the QA meeting. The QA committee will determine whether continued auditing or other interventions are necessary to achieve and maintain compliance. Documentation will be retained within the community.*

(supporting documentation is attached)

Licensee's Proposed Overall Completion Date: *10/30/2026*

Implemented 05/04/2026)

181c - Self-administration Assessment

8. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident 's most recent Resident Assessment and Support plan completed on , and respectively

181c - Self-administration Assessment (continued)

indicated the resident was not assessed to self-administer medication/s. However, at 11:51 a.m., there was a partially used tube of Remedy Protect Zinc Oxide paste on the left side of the sink located in resident [redacted] private resident bathroom.

Plan of Correction ***Accept[redacted] - 04/24/2026)***

2600.181(c)

In response to violation 2600.181c, Resident #[redacted] had a recent stay at a SNF, and [redacted] family had brought this medication back with [redacted] without notifying RCC or ED. The medication was discontinued prior to readmission to Woodcrest. Resident Assessment and Support plan completed on 4/18/25, and 5/8/25 indicates resident is unable to self-administer medications.

Immediate Response:

- *On 3/31/26, Immediately upon identification the tube of Remedy Protect Zinc Oxide paste was removed from Resident [redacted] private bathroom and disposed of by Resident Care Coordinator.*
- *All resident apartments were inspected by RCC and Medication Tech's on 4/1/2026 and no further discrepancies were found.*

Corrective Action:

- *On 4/14/2026 the Executive Director re-educated all current Med Tech's of the homes policy & procedures on medication services - self administration and the requirements set forth within 2600.181c. Documentation of this training is attached and will be retained within the community.*
- *On 4/15/2026 a letter was sent to all Residents, Family Members, and Responsible Parties providing a reminder of the guidelines on ALL medications requiring prescriptions (including OTC's), storage of medications and self-administration assessment. Documentation of this letter is attached and will be retained within the community.*

Preventative Action:

- *Starting the week of 4/20/2026, the Resident Care Coordinator or Designee will audit 4 random resident apartments weekly for 4 weeks, bi-weekly for 4 weeks, then monthly for 2 months to ensure continued compliance with regulation 2600.181c.*
- *Findings of these audits will be discussed monthly at the QA meeting. The QA committee will determine whether continued auditing or other interventions are necessary to achieve and maintain compliance. Documentation will be retained within the community.*

(supporting documentation attached)

Licensee's Proposed Overall Completion Date: *08/15/2026*

Implemented [redacted] 05/04/2026)

183d - Prescription Current

9. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

Resident [redacted] was prescribed [redacted]. Insert ¼ applicator full 1 gm., vaginally three times weekly. The

183d Prescription Current (continued)

medication was discontinued on [redacted]. However, the medication was present in the home's medication cart.

Plan of Correction ***Accept [redacted] - 04/24/2026)***

2600.183(d)

Immediate Response:

- *On 3/31/26, Immediately upon identification the Executive Director immediately removed the tube of Estradiol Vaginal Cream from the medication cart.*
- *On 4/2/2026 the Resident Care Coordinator conducted a complete audit of all medication carts, and no further discrepancies were found.*

Corrective Action:

- *On 4/14/2026 the Executive Director re-educated all current Med Tech's of the homes policies and procedures in regard to medication services and the requirements set forth within 2600.183d. Documentation of this training is attached and will be retained within the community.*

Preventative Action:

- *Starting the week of 4/20/2026, the Resident Care Coordinator or Designee will conduct a medication cart audit of 4 random residents current medications orders weekly for 4 weeks, bi-weekly for 4 weeks, then monthly for 2 months to ensure continued compliance with regulation 2600.183d.*
- *Findings of these audits will be discussed monthly at the QA meeting. The QA committee will determine whether continued auditing or other interventions are necessary to achieve and maintain compliance. Documentation will be retained within the community.*

(supporting documentation attached)

Licensee's Proposed Overall Completion Date: *08/15/2026*

Implemented [redacted] - 05/04/2026)

185a - Implement Storage Procedures

10. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident [redacted] was prescribed [redacted], inject as per sliding scale; If 201 250 2u, 251 300 4u, 301 350 6u, 351 400 8u, 401 450 10u, greater than 451 give 10 units and call MD. A blood glucose reading of [redacted] was indicated on the resident's Medication Administration record for the date/time of [redacted] at 4:30 p.m. However, the resident's glucometer indicated a glucose reading of [redacted], for the corresponding date/time.

Resident [redacted] was prescribed [redacted], 17 gm in 8 ounces of liquid by mouth every day as needed. However, the medication was not present in the home.

Resident [redacted] was prescribed [redacted] suppository give 1 suppository directly every eight hours as needed for nausea/vomiting. However, the medication was not present in the home.

Plan of Correction ***Accept [redacted] - 04/24/2026)***

2600.185(a)

185a - Implement Storage Procedures (continued)

In response to violation 2600.185(a), the medication technician requested a refill for Resident [redacted] Polyethylene Glycol and Resident #[redacted] ComPro suppository on 3/31/26 prior to the inspector's discovery. Documentation of the refill request is attached and will be retained within the community.

Immediate Response:

- *On 03/31/2026, Resident [redacted] Polyethylene Glycol 3350 and Resident #5 ComPro 25 mg suppositories were delivered to the facility from FHP pharmacy. Documentation of the delivery slip is attached and will be retained within the community.*
- *On 4/1/2026 the Resident Care Coordinator and ED completed an audit of medications carts to ensure all current medications were available for administration per MD orders. RCC also completed an audit of all glucometer's comparing the readings to the corresponding resident MAR for March, and no further discrepancies were found.*

Corrective Action:

- *On 4/14/2026 the Executive Director re-educated all current Med Tech's of the requirements set forth within 2600.185(a). and of the homes medication's policies and procedures for current prescriptions/medication storeage and with emphasis on the importance of accurate transcription from blood glucose meter recordings and the ability to recall readings for accurate documentation on the MAR.*
- *Documentation on this training is attached and will be retained within the community.*

Preventative Action:

- *Starting the week of 4/20/2026, the Resident Care Coordinator or Designee will audit/compare all glucometers readings to the MAR for accurate transcription 3x's a week for 4 weeks, 2x's a week for 4 weeks, then weekly for 4 weeks to ensure continued compliance with regulation 2600.185(a)*
- *Starting the week of 4/20/2026, the Resident Care Coordinator or Designee will conduct a medication cart audit of 4 random residents weekly for 4 weeks, bi-weekly for 4 weeks, then monthly for 2 months to ensure continued compliance with regulation 2600.183a.*
- *Findings of these audits will be discussed monthly at the QA meeting. The QA committee will determine whether continued auditing or other interventions are necessary to achieve and maintain compliance. Documentation will be retained within the community.*

(supporting documentation is attached)

Licensee's Proposed Overall Completion Date: *07/20/2026*

Implemented [redacted] - 05/04/2026)