



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **FAWN CARE LLC**

LEGAL ENTITY

To operate **FAWN CARE**

NAME OF FACILITY OR AGENCY

Located at **282 SHAWNDEROSA DRIVE, TARENTUM, PA 15084**

(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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To provide **Personal Care Homes**

TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **16**
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 2600: Personal Care Homes

(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **July 16, 2026** until **January 16, 2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **454052**

[Signature]
ISSUING OFFICER

[Signature]
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]
Fawn Care LLC
[REDACTED]

RE: Fawn Care
License #: 454052

[REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on April 13, 2026, April 14, 2026, and August 17, 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. 2600 (relating to Personal Care Homes), the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND 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) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from July 16, 2026 to January 16, 2027.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), 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 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 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
Forum Place, 6th Floor
PO Box 2675

Harrisburg, PA 17105-2675

[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

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: *FAWN CARE* License #: *45405* License Expiration: *07/16/2026*
Address: *282 SHAWNDEROSA DRIVE, TARENTUM, PA 15084*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *FAWN CARE LLC*

Address: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Type: *R-4* Date: *05/11/2017* Issued By: *Middlesex Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *18* Waking Staff: *14*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Complaint, Provisional* Exit Conference Date: *04/14/2026*

Inspection Dates and Department Representative

04/13/2026 - On-Site [REDACTED]

04/14/2026 - On-Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *16* Residents Served: *15*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *1*

Are 60 Years of Age or Older: *15*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *1*

Have Mobility Need: *3*

Have Physical Disability: *0*

Inspections / Reviews

04/13/2026 - Full

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *05/31/2026*

06/23/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *06/01/2026*

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *06/30/2026*

07/09/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *06/30/2026*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *08/10/2026*

09/24/2026 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *08/10/2026*

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

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

The resident-home contract, dated 3-18-26 for resident # [REDACTED] was missing the signature page and not signed by the resident or the home's administrator/designee.

Plan of Correction

Accept ([REDACTED] 07/02/2026)

[REDACTED] and [REDACTED] administrator/staff person.A conducted the compliance review of all current resident Home contracts on 6/1/2026 after the missing signature page for resident number one was located and the contract was fully signed [REDACTED] implemented the mandatory intake checklist 161- 2026 the checklist became effective immediately on 6/1/2026 and requires a second administrative review of residence home contract within 48 hours of admission to verify required signatures [REDACTED] administrator began reviewing auditing new administer mission contracts on 6/1/2026 new resident Home contracts will be reviewed before filing and again within seven days of admission to confirm all required signatures are present supporting documentation signed resident number one contract signature page and updated intake. Checklist are maintained by the facility.

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

Implemented ([REDACTED] - 09/23/2026)

25c12 - Bed Hold

2. Requirements

2600.

25.c. At a minimum, the contract must specify the following:

12. Charges to the resident for holding a bed during hospitalization or other extended absence from the home.

Description of Violation

The resident-home contract, dated 3-18-26 for resident # [REDACTED] did not include the charges for holding a bed during an absence.

Plan of Correction

Directed ([REDACTED] - 07/07/2026)

[REDACTED] updated the standard resident Home contract template on 6/1/2026 to require the bed hold charge section to be completed before the contract is printed signed and filed [REDACTED] administrator began reviewing all newly executed contracts on 6/1/2026 to ensure bed hold charges for hospitalization or other extended absence are explicitly detailed or marked not political with explanation supporting documentation resident number one behold addendum and updated contract template are maintained by the facility.

Proposed Overall Completion Date: 06/30/2026

DIRECTED: Per the home's original plan of correction, received on 6/1/2026:

An addendum to Resident [REDACTED] contract dated 3-18-26 was drafted, signed and executed to clearly specify the correct daily charges for holding a bed during hospitalizations or extended absences.

The standard resident-home contract template used by Fawn Care was updated to ensure the section regarding hospital and extended absence bed hold fees is a mandatory, non blank field before printing.

25c12 - Bed Hold (continued)

The administrator will review all newly executed contracts moving forward to ensure bed hold charges are explicitly detailed.

7.9.26

Directed Completion Date: 08/10/2026

Implemented 09/23/2026)

64c - Annual Training**3. Requirements**

2600.

64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff person A, the home's administrator, did not complete any Department-approved training in the calendar training year for 2025.

Plan of Correction

Directed 07/07/2026)

Staff person A is Administrator, staff person A provided administrator training documentation to Kimberly fair and the administrator personnel training file on 6-1-2026. Trainings were located up-to-date trainings were done files were created and organized for easy access when needed. files were located, organized, and available at the facility for viewing. in addition, the documentation provided included available administrator training certificates and training records for the 2025 training year if the 2025 department approved administrator training hours total less than 24 hours in which they do not the missing 2025 hours will be completed. In addition to the 24 hours required 2026 and proof of completion will be maintained in the administrator training file Kimberly fair created the annual professional development tracker for the administrator on 6/1/2026 the tracker began used on 6/1/2026 Owner legal entity representative began by annual administrator. Training reviews on 6/1/2026. Review reviews will occur at least twice a year to verify the administrator remains on track for required training hours.

Proposed Overall Completion Date: 06/30/2026

DIRECTED: 24 make-up hours of Department-approved administrator training for the 2025 training year will be submitted to the Department by August 10, 2026. Documentation of training will be recorded in accordance with 65i. A training plan for staff person A, that includes an additional 24 hours of Department-approved administrator training for the 2026 training year, to be completed by December 31, 2026 will be documented in accordance with 66b-c and will be submitted to the Department by August 10, 2026. 7.9.26

Directed Completion Date: 08/10/2026

Not Implemented 09/23/2026)

65d - Initial Direct Care Training**4. Requirements**

2600.

65d - Initial Direct Care Training (continued)

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person B, hired on [REDACTED] began providing unsupervised ADL services on that date. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction

Accept ([REDACTED] - 07/07/2026)

Staff person B remain, remains employed by the home only in duties permitted by current training status and may not provide unsupervised ADL services unless until the department approved direct care training course and competency test are successfully completed in documented staff person B was removed for on supervised ADL service until 413 2026 staff person B has completed the department approved direct care, training course and competency test before being scheduled for unsupervised ADL duties. Documentation has been placed in the Personal file once it was completed as well as located. It was re-completed [REDACTED] updated the onboard protocol on 6/1/2026. The updated protocol began used on 6/1/2026 and identifies new hires as supervised only until required training and competency. Documentation is in the personal file [REDACTED] administrator began reviewing new hires files for required training documentation on 6/1/2026 before scheduling staff for independent shifts files were located and will continue to be reviewed.

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

Implemented ([REDACTED] - 09/23/2026)

65f - Training Topics**5. Requirements**

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

Description of Violation

Direct care staff persons B, C and D did not receive training in the following topics during the 2025 calendar training year:

-Medication Self Administration.

-Instructions on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

Plan of Correction

Accept ([REDACTED] - 07/07/2026)

Staff person B,C& D completed remediation training on medication self administration and instruction on meeting residents needs for the pre-admission screening assessment tool medical evaluation and support plan as part of the facility training completed on May 2026, including the May 20, 2026 plan of correction Training and May 22, 2026 annual 12 hour training curriculum. Attached will be several trainings. In addition multiple trainings are located at

65f - Training Topics (continued)

the facility. Any review would like to be confirmed [REDACTED] conducted the training hospice also provided in-service training where applicable to resident Care needs [REDACTED] re-organize a facility annual training calendar on 6/1/2026 so required core. Topics are addressed early in the calendar year and tracked in the staff training brackets [REDACTED] administrator began reviewing staff training records on 6/1/2026 required training records will be maintained as required. No additional non-required logs will be created unless deficiency is identified.

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

Implemented [REDACTED] - 09/23/2026)

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:

4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

Description of Violation

Staff persons B, C, and D did not receive training in the following topics during the 2025 calendar training year:

-The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102)

-Falls and accident prevention

Plan of Correction

Accept [REDACTED] - 07/07/2026)

Staff person B,C,D completed training on the older adult protective service act and falls/accident prevention as part of the May 2026 remediation annual training including the May 20,2026 plan of corrections Training and May 22, 2026 annual 12 hour training curriculum [REDACTED] conducted the training as well as hospice these required. Topics were integrated in the mandatory annual compliance curriculum by [REDACTED] on 6/1/2026 [REDACTED] administrator began redoing staff training records for required an annual topics on 6/1/2026 any missing required topic identified during review will be assigned for completion .

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

Implemented [REDACTED] - 09/23/2026)

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

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On [REDACTED], there was a green "scrunchi" type sponge hanging from the shower and a gray "scrunchi" type sponge laying on the floor in the shower stall in common bathroom #1. There was also a used washcloth on the floor in the shower stall.

On [REDACTED], there was a heavy coating of white dust and lint on the louvered vents of the ceiling fan in common bathroom #1.

85a - Sanitary Conditions (continued)

Plan of Correction

Directed [REDACTED] 07/09/2026)

On April 13, 2026 staff person B immediately removed the Green and Grey loofah/scrunchie sponges and use washcloths from the common bathroom. Number one during the inspection items were discarded or laundered as appropriate, and the shower area was clean, cleansed and sanitized the bathroom ceiling fan vent was cleaned on April 15, 2026 by facility staff see under direction of K [REDACTED]. The facility staff also completed ventilation exhaust fan training on April 15, 2026 conducted by [REDACTED] covering bathroom, exhaust fan maintenance and reporting concerns [REDACTED] revise the bathroom sanitation procedure on April 5, 2026 to include visual checks for left behind personal items in shower area invisible dust lint on bathroom vents [REDACTED] administrator began routine walk-through reviews of common bathrooms on April 15, 2026. Any sanitation concerns observed during walk-throughs will be corrected immediately and reported to the administrator or owner. If follow up is needed documentation of pictures are provided in this plan of correction.

Proposed Overall Completion Date: 06/30/2026

DIRECTED: Within 24 hours of receipt of the plan of correction, the administrator or designee will begin conducting daily walk-through audits of sanitary conditions in all bathrooms for 2 weeks. Weekly walk-through audits will be conducted weekly thereafter for one month. Written logs verifying the completion of all audits will be maintained.

[REDACTED] 7.9.26

Directed Completion Date: 08/10/2026

Implemented [REDACTED] 09/23/2026)

91 - Telephone Numbers

8. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On [REDACTED], there were no emergency telephone numbers, to include the nearest hospital and fire department, on or by the telephone in bedroom [REDACTED]

Plan of Correction

Directed [REDACTED] 07/09/2026)

[REDACTED] posted the required emergency telephone numbers by the telephone in bedroom number six on April 13, 2026 A facility wide suite was completed on April 13, 2026 by [REDACTED] and [REDACTED] to verify that required emergency numbers were posted at political telephone locations, [REDACTED] administrator began checking required. Emergency numbers postings during routine safety walk-throughs on April 13, 2026 missing or damaged postings will be replaced immediately when identified.

Proposed Overall Completion Date: 06/30/2026

DIRECTED: Within 24 hours of receipt of the plan of correction, the administrator or designee will begin conducting daily walk-through audits of all telephones with outside lines in the home for required phone numbers. Weekly walk-through audits will be conducted weekly thereafter for one month. Written logs verifying the completion of all audits will be maintained. [REDACTED] 7.9.26

91 - Telephone Numbers (continued)

Directed Completion Date: 08/10/2026

Implemented [REDACTED] - 09/23/2026)

95 - Furniture and Equipment

9. Requirements

2600.

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

Description of Violation

On [REDACTED] the ceiling fan on the right side of the outside deck on the back porch was not securely attached and was hanging down precariously, exposing the wiring.

Plan of Correction

Directed [REDACTED] 07/09/2026)

On April 13, 2026 power to the exterior porch ceiling fan was turned off by [REDACTED] to eliminate the immediate hazard staff person C removed/knocked down the wasp mudd/Dauber nest from the fan area on the day of inspection April 13, 2026. The Porch ceiling fan was secured and repaired by [REDACTED] Administrator after the inspection (4/17/26) the repair corrected the loose van condition and enclose secured the area, so the fan is no longer hanging precariously & lose. A facility wide visual maintenance assessment of indoor and outdoor ceiling fixtures was completed by [REDACTED] and [REDACTED] following the inspection. Ceiling fans and porch structures were added to the routine maintenance walk-through review on June 1, 2026 by [REDACTED] the administrator or designate [REDACTED] will monitor ceiling fans and porch structures during routine walk-through any maintenance concerns identify will be corrected promptly and reported to the administrator or owner of future action is required. Verbal Documentation will be completed when a repair or deficiency is identified by any personnel. Maintenance for repairs will be carried out by staff person A (Administrator) for Repair.

Proposed Overall Completion Date: 06/30/2026

DIRECTED: Within 24 hours of receipt of the plan of correction, the administrator or designee will begin conducting daily walk-through audits of porch ceiling fans and structures for 2 weeks. Weekly walk-through audits will be conducted weekly thereafter for one month. Written logs verifying the completion of all audits will be maintained. [REDACTED]

7.9.26

Directed Completion Date: 08/10/2026

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

101j2 - Bedroom Chairs

10. Requirements

2600.

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

2. A chair for each resident that meets the resident's needs.

Description of Violation

On [REDACTED] bedroom [REDACTED] was occupied by 2 residents; however, there was only 1 chair in this room.

Plan of Correction

Directed [REDACTED] - 07/09/2026)

Staff person be placed an additional appropriate chair in bedroom number six on April 13, 2026 so that each resident assigned to the room had a chair that met the residence needs Kimberly fair updated room set up

101j2 - Bedroom Chairs (continued)

expectations on June 1, 2026 to require a review of resident room furnishings when a resident moves in transfers rooms or shares a room [REDACTED] administrator began reviewing room occupancy and resident furniture during routine building walk-through on June 1, 2026 any missing required furniture will be corrected immediately when I identified.

Proposed Overall Completion Date: 06/30/2026

DIRECTED: Within 24 hours of receipt of the plan of correction, the administrator or designee will begin conducting daily walk-through audits of all resident bedrooms to ensure the required number of chairs are present for 2 weeks. Weekly walk-through audits will be conducted weekly thereafter for one month. Written logs verifying the completion of all audits will be maintained. [REDACTED] 7.9.26

Directed Completion Date: 08/10/2026

Implemented [REDACTED] - 09/23/2026)

102i - Soap Dispenser**11. Requirements**

2600.

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On [REDACTED], there was no soap at the sink in common bathroom #1.

Plan of Correction

Directed [REDACTED] 07/09/2026)

Staff person B placed soap at the sink in common bathroom number one on April 13, 2026 all handwashing stations and bathrooms were checked on April 13, 2026 by staff person B and [REDACTED] to ensure soap was present staff on duty were instructed on April 13, 2026 by [REDACTED] to check bathroom soaps available during routine housekeeping and resident care duties. The instruction applied to all direct care staff working in the home beginning on April 13, 2026 staff routine cleaning house keeping rounds include checking that soap stocked in bathroom. Any missing soap will be placed immediately and reported to the administrator or Owner if supplies are low or repeated concerns or identified. Training was held documentation provided attached.

Proposed Overall Completion Date: 06/30/2026

DIRECTED: Within 24 hours of receipt of the plan of correction, the administrator or designee will begin conducting daily walk-through audits of all bathrooms to ensure a dispenser with soap is present at all bathroom sinks for 2 weeks. Weekly walk-through audits will be conducted weekly thereafter for one month. Written logs verifying the completion of all audits will be maintained. [REDACTED] 7.9.26

Directed Completion Date: 08/10/2026

Implemented [REDACTED] - 09/23/2026)

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's maximum safe evacuation time designated in writing by a fire safety expert on [REDACTED] is 2 minutes and 1 second. According to the home's fire drill records, the evacuation time for the drill on [REDACTED] was 2 minutes 39 seconds and on [REDACTED] was 4 minutes 3 seconds.

Plan of Correction

Directed [REDACTED] - 07/09/2026)

Fire safety evacuation training was completed on May 18, 2026. The training was conducted by [REDACTED] fire safety source with facility staff participation and included evacuation procedure staff responsibilities, fire, safety and prevention. This was a retraining. Documentation is provided fire drill procedures were reviewed and updated by [REDACTED] and [REDACTED] on May 18, 2026 staff rules during an alarm include directing residence to the designated exit routes assisting residence who require mobility and queuing support checking assisted areas is safe to do so bringing attendance accountability information calling 911 as needed and reporting to the outside

132d - Evacuation (continued)

meeting fire safety area . Effective May 18, 2026 if a fire drill exceeds two minutes 30 seconds, [REDACTED] administrator design will conduct a debriefing with staff and drill. We will be completed as soon as practical to improve evacuation performance effective May 18, 2026, [REDACTED] administrator will supervise in time for fire drills to ensure evacuation performance remains at the correct benchmark referred by the fire department required fire drill. Documentation will continue to be maintained. Retraining, staff is documented and signed by staff.

Proposed Overall Completion Date: 06/30/2026

DIRECTED: Within 24 hours of receipt of the plan of correction, the administrator will complete the following steps after fire drills where evacuation time exceeds 2 minutes 30 seconds:

- additional drills will be held until evacuation is completed within 2 minutes 30 seconds. Documentation of additional drills will be kept.
- provide education on fire drill policies and procedures to staff and residents. Documentation of education will be kept.
- increase staffing levels to reduce evacuation time to within 2 minutes 30 seconds

7.9.26

Directed Completion Date: 08/10/2026

Not Implemented [REDACTED] 09/23/2026)

141b1 - Annual Medical Evaluation**14. Requirements**

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident [REDACTED] annual medical evaluation, dated [REDACTED] is missing the last page of the form which includes the medical professional's name, provider license #, signature, and date signed, and the certification that the resident's needs can be met safely at the personal care home.

Plan of Correction

Accept [REDACTED] 07/09/2026)

The DME correction was requested from resident number two primary care physician, [REDACTED] by [REDACTED] after the inspection when the missing final page was identified the request was made so the medical professional information license number and signature date and certification that the resident needs can be met safely at the home would be complete. The updated DME final page was received from the medical provider office and added to resident number two chart by [REDACTED] facility records contain the exact receive date and completed medical provider information April 23, 2026 a medical record quality review for current residence was completed by [REDACTED] fair on June 1, 2026 to check for incomplete or missing DME pages effective June 1, 2026 [REDACTED] administrator will review incoming DM's for completion before filing them and the residence charts. If any page or signature is missing the form will be returned requested for correction before being considered complete.

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

Implemented [REDACTED] 09/23/2026)

183e - Storing Medications

15. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On [REDACTED] at approximately 9:45 am, one card of resident [REDACTED]'s [REDACTED] tablets, 'take 1 tablet 3 times a day' was ripped open on one side, exposing 4 of the tablets which were then taped over.

Repeated Violation: [REDACTED]

Plan of Correction

Directed [REDACTED] - 07/09/2026)

The pharmacy was contacted on April 15, 2026 by [REDACTED] regarding the compromised [REDACTED] medication card. The medication card was Corn and Pharmacy direction was requested for safe handling repackaging replacement and verification of medication integrity staff for re-educated on medication storage and compromise medication packaging on May 20, 2026 by [REDACTED] and pharmacist [REDACTED] staff were instructed that compromise medication packaging must be reported to the supervisor administrator and Pharmacy and must not be taped over or used without Pharmacy direction [REDACTED] administrator also conducted this training. [REDACTED] began random medication cart reviews on June 1, 2026. These reviews focused on medication, packaging condition, organization, sanitation, and proper storage. Any issues identified will be corrected immediately and reported to Pharmacy when required [REDACTED], pharmacist with script pharmacy will do monthly audits of Med card starting June 1, 2026.

Proposed Overall Completion Date: 06/30/2026

DIRECTED: Documentation of monthly medication audits conducted with the pharmacist will be maintained. [REDACTED]
7.9.26

Directed Completion Date: 08/10/2026

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

190a - Completion Medication Course**16. Requirements**

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person B, who has not successfully completed the Department-approved medications administration course, has administered medications to residents, to include the following:

- On [REDACTED] at 9:00 pm, [REDACTED] take 1 tablet daily; [REDACTED], take 1 tablet at bedtime and [REDACTED], take 1 tablet at bedtime for resident [REDACTED]
- On [REDACTED] at 9:00 am, [REDACTED] apply to affected area 2 times a day for 10 days; [REDACTED], take 1 tablet every morning; [REDACTED], take 1 capsule by mouth every morning; [REDACTED], take 1 tablet by mouth every morning for resident [REDACTED]
- On [REDACTED] at 9:00 am [REDACTED], take 2 tablets by mouth every morning and every evening; [REDACTED] take 1 tablet by mouth every morning and every evening, [REDACTED], take 1 tablet by

190a - Completion Medication Course (continued)

mouth every morning, [REDACTED] take 1 capsule by mouth every morning, for resident [REDACTED]

Plan of Correction

Accept [REDACTED] - 07/09/2026)

Staff person be remains employed only in duties permitted by current training certification status and does not pass medications unless and until the department approved, medication administration, course and performance based competency test or successfully completed a document sad person B has not been permitted to administer medication's after the deficiency was identified less required medication administration certification, and competency. Documentation is completed and verified in the Personal file [REDACTED] administrator began weekly scheduled review on June 1, 2026 to ensure that medication administration is a sign only to staff with current verified medication, administrative course and competency, documentation medication cart, keys, and MAR access or limited to authorize certified staff.

Proposed Overall Completion Date: 06/30/2026

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

Implemented [REDACTED] - 09/23/2026)

191 - Resident Right to Refuse**17. 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] records do not include documentation that the resident has been educated of the resident's right to question or refuse medication if the resident believes there may be a medication error.

Plan of Correction

Accept [REDACTED] - 07/09/2026)

Resident number one file was located documentation organized however, in addition, resident one was re-educated on the right to question or refuse a medication. If the resident believes there may be a medical error. The education was documented, signed and placed in resident number one record. In addition retraining was done for all current staff to make sure it is in their files, [REDACTED] added residence medication rights to question refuse education to the standard admission process and an annual resident review checklist on June 1, 2026 the updated admission and annual review checklist began on June 1, 2026 [REDACTED] administrator conducted a chart review on June 1, 2026 to verify that resident medication right to question and refuse education. Documentation was president and resident records. Any missing form identified will be completed with the resident and filed in the resident records.

Proposed Overall Completion Date: 06/30/2026

Licensee's Proposed Overall Completion Date: 07/09/2026

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

224a - Preadmission Screen Form**18. Requirements**

224a - Preadmission Screen Form (continued)

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident [REDACTED] preadmission screening form, dated [REDACTED] was missing the second page which includes the following required information:

- Medical Needs
- Activities of Daily Living
- Instrumental Activities of Daily Living
- Sensory Needs
- Medical, Psychological and Behavioral Diagnoses
- History of Problematic Behaviors
- If the Resident Can Safely Use and Avoid Poisonous Materials
- If the Needs of the Applicant Can Be Met in the Personal Care Home

Plan of Correction**Accept [REDACTED] 07/09/2026)**

Resident number one pre-admission screening was completed prior to admission however, page 2 was missing from the foul. The missing second page was secured after the inspection and detached resident number one master file. They completed pre-admission screening for identifies resident needs, and whether those needs can be met with the personal care home [REDACTED] modify the intake packet assembly protocol on June 1, 2026 to require all multiple page admission documents, including pre-admission screening forms to be scanned and filed as one complete document the updated intake packet assembly protocol was implemented on June 1, 2026. The pre-admission checklist began used on June 1, 2026. It requires verification that all pages of pre-admission screening our present before admission paperwork is considered complete [REDACTED] administrator begin reviewing admission documentation before move-in on June 1, 2026 to verify the pre-admission screening contract medical evaluation and other required admission documents are complete.

Proposed Overall Completion Date: 06/30/2026

Proposed Overall Completion Date: 08/10/2026

Licensee's Proposed Overall Completion Date: 07/09/2026

Implemented [REDACTED] 09/23/2026)

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

Facility Information

Name: *FAWN CARE* License #: *45405* License Expiration: *07/16/2026*
Address: *282 SHAWNDEROSA DRIVE, TARENTUM, PA 15084*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *FAWN CARE LLC*

Address: [REDACTED]

Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *R-4* Date: *05/11/2017* Issued By: *Middlesex Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *17* Waking Staff: *13*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Provisional, Interim* Exit Conference Date: *08/17/2026*

Inspection Dates and Department Representative

08/17/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *16* Residents Served: *14*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *2* Are 60 Years of Age or Older: *11*
Diagnosed with Mental Illness: *3* Diagnosed with Intellectual Disability: *3*
Have Mobility Need: *3* Have Physical Disability: *0*

Inspections / Reviews

08/17/2026 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/17/2026*

Inspections / Reviews (*continued*)

09/18/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/17/2026

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 09/25/2026

09/21/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/18/2026

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 09/25/2026

09/24/2026 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/21/2026

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

95 - Furniture and Equipment

1. Requirements

2600.

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

Description of Violation

The toilet in the first bathroom on the right hand side of the hallway was not secured in place to the floor and could be slid back and forth approximately 5 to 6 inches to the left and right.

Plan of Correction

Accept [REDACTED] - 09/21/2026)

On 8/17/26 [REDACTED] made the repair at 9:03 pm. this repair was also inspected in person by [REDACTED] 8/25/26. Check list also shown in person to [REDACTED] 8/25/26 in person when state visit. [REDACTED] who is the Administrator began monthly site walk through monthly check on 8/17/26. Daily Visual Site check began on 8/17/26 by [REDACTED] continue. Staff will report issue to Administrator if any issues or concerns are seen. Check list included and was seen by [REDACTED] her last state visit on 8/25/26. I included this yesterday when submitted but will also include again today.

.FAWN PERSONAL CARE HOME

DAILY FACILITY CHECKLIST - AM / PM

Date:

AREA

Day:

WHAT TO CHECK

AM

PM

NOTES / INITIALS

Resident safety / supervision

Residents accounted for; walkways clear; no immediate hazards.

Bedrooms

Bathrooms

Rooms orderly; required furniture/chairs present; no unsafe clutter.

Clean and dry; soap/paper products available; fans/vents clean; no personal-care items left in common areas. Item in good repair.

Kitchen / dining

Surfaces clean; food protected; opened/prepared food properly labeled and dated.

95 - Furniture and Equipment (continued)*Pantry /**refrigerators**No expired/spoiled food; refrigerator/freezer secure and temperatures acceptable.**Medication area**Medication storage secured; medication area/MARs orderly; concerns reported.**Laundry / utility areas**Clean and safe; chemicals secured; laundry room/required doors kept closed.**Exits / hallways / stairs**Clear and unobstructed; exit doors accessible; no trip hazards.**Alarms / emergency**safety**Exit alarms/safety devices appear operational; emergency information accessible.**Fire safety**Extinguishers/exits unobstructed; no blocked fire-safety equipment.**Smoking area**Designated area clean; cigarette butts/debris removed; receptacle used; walkway sprayed/clean as needed.**Outside / entrance**Walkways and entrance clean; papers/trash removed; rugs/mats safe and not frayed.**Fans / vents*

95 - Furniture and Equipment (continued)

Bathroom, kitchen and bedroom fans/vents visibly clean and free of heavy dust.

Resident personal items

Hairbrushes, loofahs, washcloths, hair ties and other personal items stored with the correct resident.

General cleanliness

Floors, common areas, furniture and high-touch areas clean and presentable.

Repairs /

maintenance

*for leaks, broken items, damaged screens, loose rugs,
lignung or other needed repairs.*

Resident concerns

Any change, complaint, refusal, incident or safety concern documented and reported as required.

mediate concerns / corrective action taken:

1 Staff Signature:

_Time:

PM Staff Signature:

George)Administrator (shown in pic and email info also states this name,date of repair and supports information requested). FAWN PERSONAL CARE HOME

MAINTENANCE / IMMEDIATE CORRECTIVE ACTION RECORD

55 Pa. Code Chapter 2600

Time Completed: 9:03 PM

Maintenance

Issue:

Loose Toilet

Date:

Location:

August 17, 2026

Bathroom #3

ISSUE IDENTIFIED

During the facility inspection, the located in Bathroom #3 was identified as being loose and in need of

95 - Furniture and Equipment (continued)

repair.

IMMEDIATE CORRECTIVE ACTION

The issue was addressed immediately. The in Bathroom #3 was inspected, secured, tightened, and repaired as necessary to eliminate movement and ensure that the was stable and safe for resident use. Following the repair, the was checked to verify that it was secure, stable, functioning properly, and free of an apparent safety hazard.

Repair Status:

Date Repair Completed:

COMPLETED

August 17, 2026

Time Repair Completed:

9:03 PM

PERSON COMPLETING REPAIR

Administrator

Fawn Personal Care Home

Signature:

Date: August 17, 2026

Time: 9:03 PM

ADMINISTRATIVE VERIFICATION

The identified maintenance concern was corrected promptly upon is entification. Bathroom #3 was returned to normal resident use following completion and verification of the Verified By: _Administrator

Title:

Date:

g-|n/l

Next to last bottom pertains to toilet.

Above is the form copied that was sent to show who repaired,date,time.

Licensee's Proposed Overall Completion Date: 09/18/2026

Not Implemented - 09/23/2026)

132d - Evacuation

3. 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.

132d - Evacuation (continued)

Description of Violation

The home's maximum safe evacuation time designated in writing by a fire safety expert on the document dated 5/18/2026 is 6 minutes 18 seconds. According to the home's fire drill records, the evacuation time for the drill on 8/1/2026 was 8 minutes and 1 second.

Plan of Correction

Accept [REDACTED] - 09/18/2026)

FAWN PERSONAL CARE would like to respectfully

DISPUTE OF CITATION/ REQUEST FOR REVIEW

Plan of Correction - 55 Pa. Code § 2600.132(d) - Fire Drills / Evacuation

Position of the Home

Fawn Personal Care respectfully disputes the citation issued under 55 Pa. Code § 2600.132(d) and requests that the Department review the citation together with the supporting documentation submitted by the home. The fire drill conducted on August 1, 2026 exceeded the maximum evacuation time established in writing by the fire safety expert. Because the drill occurred at the beginning of the month, Section 2600.132(a) requires that an unannounced fire drill be held at least once a month. The regulation does not limit a Personal Care Home to only one fire drill per month or prohibit the facility from conducting an additional drill when corrective action is necessary. Fawn Personal Care home conducted an additional fire drill during August 2026. The follow-up drill was completed within the required evacuation time. Documentation provided below .

The successful follow-up August 2026 fire drill record is included with this Plan of Correction and will be submitted/resubmitted to the Department today as supporting documentation.

Fawn Personal Care respectfully requests that the Department consider the prompt corrective action, the successful follow-up drill, staff training, and the home's demonstrated ability to complete evacuation within the maximum time established by the fire safety expert when reviewing the citation.

Corrective Action and Ongoing Monitoring

Director [REDACTED] will oversee compliance with § 2600.132 and will review the written documentation after each monthly fire drill. The review will include verification of the evacuation time against the maximum time established by the fire safety expert and verification that the required fire-drill documentation. If a future drill exceeds the designated maximum evacuation time, the Director will promptly review the cause of the delay, address any identified problems, provide additional staff instruction or retraining as necessary, and ensure that corrective follow-up is completed and documented. Fire-drill records and related corrective-action and training documentation will be maintained at the home and made available for Department review.

Staff Training / Preventive Action

As an additional corrective and preventive measure, a 15-minute staff training was conducted on August 19, 2026. The training reviewed evacuation procedures, resident assistance, prompt response to the alarm, established evacuation routes, the designated safe meeting area, accurate fire-drill documentation, and the importance of completing evacuation within the maximum safe evacuation time established by the fire safety expert.

Statement Regarding Dispute

The corrective measures and supporting documentation provided in this Plan of Correction are submitted to demonstrate the home's continued compliance efforts and resident-safety practices and should not be construed as a waiver of the home's position disputing the citation.

Responsible Person: [REDACTED], Director

Supporting Documentation: Successful follow-up August 2026 fire drill record and 08/19/2026

132d - Evacuation (continued)

Licensee's Proposed Overall Completion Date: 09/17/2026

Not Implemented (09/23/2026)

191 - Resident Right to Refuse

4. 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] admitted [REDACTED] does not have documentation that the resident has been educated to the resident's right to refuse medication if the resident believes that there may be a medication error in their record.

Resident [REDACTED] admitted [REDACTED] does not have documentation that the resident has been educated to the resident's right to refuse medication if the resident believes that there may be a medication error in their record.

Resident [REDACTED] admitted [REDACTED] does not have documentation that the resident has been educated to the resident's right to refuse medication if the resident believes that there may be a medication error in their record.

Plan of Correction

Accept [REDACTED] 09/18/2026

Plan of Correction

On 08/17/2026, all current residents were re-trained/re-educated regarding their resident medication rights under §2600.191. The

education included the resident's right to question or refuse a medication if the resident believed there may be a medication error, the right to

ask staff questions about medications before taking them, and the right to question or refuse a medication if the resident believed the

medication, dose, or administration time may be incorrect.

The resident education was provided by [REDACTED] and [REDACTED] Director/Administrator. Every resident received the

education. Each resident had an individual Resident Medication Rights Education/Addendum form, and each resident signed and dated his or

her own form documenting the education. The signed forms were maintained in the residents' records. Proof included in this paperwant also.

The completed resident education paperwork is included with this submission. The 08/17/2026 email and corrective documentation

previously submitted are also included as supporting documentation.

To prevent recurrence, resident-rights education will be completed upon admission and reviewed annually thereafter. The

Director/Administrator, or designee, will verify that required education documentation is completed, signed, dated, and maintained in each

resident's record. Resident records will be periodically reviewed for continued compliance.

The facility's ongoing visual/review checklist, which began in July 2026 and continues, is being used as an additional monitoring measure.

Any missing documentation or other issue identified during review is reported to Kim Fair and/or the Director/Administrator and corrected

191 - Resident Right to Refuse (continued)

promptly.

SEE ATTACHMENTS - 6 ATTACHMENTS

Please review all six attachments submitted with this Plan of Correction, including the signed resident education forms, the 08/17/2026 Signed & trained by EVERY RESIDENT. this also was submitted via email. I will attach proof of that below..

email/corrective documentation, resident-record review documentation, and the ongoing facility checklist.

Licensee's Proposed Overall Completion Date: 09/17/2026

Not Implemented ██████████ **09/23/2026)**