

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

June 3, 2026

[REDACTED] QUALITY MANAGEMENT SPECIALIST  
REMED RECOVERY CARE CENTERS  
[REDACTED]

RE: REMED-GIBSONIA  
3043 EAST BARDONNER ROAD  
GIBSONIA, PA, 15044  
LICENSE/COC#: 45633

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/14/2026 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: <i>REMED-GIBSONIA</i>	License #: <i>45633</i>	License Expiration: <i>03/25/2027</i>
Address: <i>3043 EAST BARDONNER ROAD, GIBSONIA, PA 15044</i>		
County: <i>ALLEGHENY</i>	Region: <i>WESTERN</i>	

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

Legal Entity		
Name: <i>REMED RECOVERY CARE CENTERS</i>		
Address: [REDACTED]		
Phone: [REDACTED]	Email: [REDACTED]	

Certificate(s) of Occupancy		
Type: <i>Other</i>	Date: <i>11/21/2025</i>	Issued By: <i>Twp. of Hampton</i>

Staffing Hours		
Resident Support Staff: <i>0</i>	Total Daily Staff: <i>16</i>	Waking Staff: <i>12</i>

Inspection Information		
Type: <i>Full</i>	Notice: <i>Unannounced</i>	BHA Docket #:
Reason: <i>Renewal</i>	Exit Conference Date: <i>04/14/2026</i>	

Inspection Dates and Department Representative	
<i>04/14/2026 - On-Site: [REDACTED]</i>	

Resident Demographic Data as of Inspection Dates			
General Information			
License Capacity: <i>8</i>		Residents Served: <i>8</i>	
Secured Dementia Care Unit			
In Home: <i>No</i>	Area:	Capacity:	Residents Served:
Hospice			
Current Residents: <i>1</i>			
Number of Residents Who:			
Receive Supplemental Security Income: <i>1</i>		Are 60 Years of Age or Older: <i>6</i>	
Diagnosed with Mental Illness: <i>0</i>		Diagnosed with Intellectual Disability: <i>0</i>	
Have Mobility Need: <i>8</i>		Have Physical Disability: <i>2</i>	

Inspections / Reviews		
04/14/2026 Full		
Lead Inspector: [REDACTED]	Follow-Up Type: <i>POC Submission</i>	Follow-Up Date: <i>05/16/2026</i>
05/12/2026 - POC Submission		
Submitted By: [REDACTED]	Date Submitted: <i>06/02/2026</i>	
Reviewer: [REDACTED]	Follow-Up Type: <i>Document Submission</i>	Follow-Up Date: <i>06/06/2026</i>

Inspections / Reviews (*continued*)

06/03/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/02/2026

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

17 - Record Confidentiality

1. Requirements

2600.

- 17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

*At 10:30 a.m., there was a large white three ring binder labeled "Staff Communication" setting in the corner of the unattended and accessible kitchen counter to the far right of the sink and left of the computer monitor. The binder contained confidential resident information to include notes regarding resident #1's return from hospital and notes regarding concern about resident #2 potentially eloping.*

Plan of Correction

Accept (█) - 05/12/2026

*On 4/14/26, the day of inspection, the Administrator/Clinical Specialist immediately moved the Staff Communication binder into the locked supply and records closet.*

*All staff were formally educated via written communication on 5/8/26 by the Administrator regarding the critical importance of maintaining confidentiality of resident information, including printed emails. Staff were reminded to keep the Staff Communication binder in the locked supply and records closet whenever it is to be left unattended. See attached email.*

*The Administrator (or Leadership designee) will complete random audits of staff compliance by checking to ensure the Staff Communication binder is not left unattended in a common area and that the designated storage area (supply and records closet) is locked. These random audits will occur at least 3 times weekly until 4 consecutive weeks go by without any instances of non-compliance, beginning the week of 5/11/26.*

*The Administrator will conduct the home's next quality management review by 6/5/26. Documentation of the quality management review will be kept, including documentation of staff signing off as acknowledging and understanding these expectations surrounding resident record confidentiality, and specifically related to proper storage of the Staff Communication binder.*

Licensee's Proposed Overall Completion Date: 06/05/2026

Implemented (█) - 06/03/2026

51 - Criminal Background Check

2. Requirements

2600.

- 51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

*Staff person A, hired █ had not been a resident of Pennsylvania for two years prior to working for the home. However, the home did not have a Federal Bureau of Investigation fingerprint background check completed for staff person A.*

51 Criminal Background Check (continued)

Plan of Correction

Accept (█) - 05/12/2026

On 4/20/26 Staff Person A completed FBI fingerprinting at Identigo.

On 4/27/26 it was confirmed that Staff Person A is eligible for employment under the Pennsylvania Older Adults Protective Services Act. See attached notice from the PA Department of Aging. A copy of Staff Person A's FBI fingerprint background check will be stored in their personnel files on site, and with the HR Department.

The Operations Manager will complete an audit of all personnel files to ensure there are no other employees who have not been residents of Pennsylvania within the last 2 years without FBI fingerprinting completed. If any are discovered, FBI fingerprinting will be completed as soon as possible. Audits of personnel files will be completed by 5/22/26.

Going forward, upon receiving personnel files/documents for new employees from the HR Department, the Operations Manager will check the files received to ensure that an FBI fingerprinting background check has been completed for any staff persons who has not been a Pennsylvania resident for the last 2 years.

Licensee's Proposed Overall Completion Date: 06/05/2026

Implemented (█) - 06/03/2026

65f - Training Topics

3. Requirements

2600.

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

- 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 person C, hired █ did not complete annual training in Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during the 1/1/25 through 12/31/25 staff training year.

Plan of Correction

Accept (█) - 05/12/2026

On 5/9/26 Staff Person C was provided instruction by the Administrator on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan. Documentation of this additional training was added to the Relias LMS (see attached certificate of completion) and will be on Staff Person C's transcript.

Additional training will be provided for the 2026 training year.

Beginning the week of 5/18/26, a review of training deadlines and staff that are due for upcoming required trainings will be included in the weekly Leadership Meeting, so that follow up can be coordinated as needed to ensure required trainings are completed within their designated deadlines.

Staff will be assigned specific times during their working hours to be off of the floor to complete required annual trainings, when staffing allows. In November/December, Leadership staff will be assigned to cover the floor at specific times to ensure all staff completed all required annual required trainings by the 12/31/26 deadline.

65f - Training Topics (continued)

The Administrator will conduct the home's next quality management review by 6/5/26. Documentation of the quality management review will be kept, including documentation of staff signing off as acknowledging and understanding expectations surrounding timely completion of all required annual trainings.

Licensee's Proposed Overall Completion Date: 06/05/2026

Implemented (█) - 06/03/2026

100a - Exterior - Free of Hazards

4. 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

At 10:22 a.m., there was a rubber hose lying across the bottom of the ramp from the back deck outside the kitchen exit door that alarms to the inside of the home when it is wheeled over. The hose was secured to the ground with brackets, but the hose loosened easily causing a tripping hazard.

Plan of Correction

Accept (█) - 05/12/2026

On 4/14/26, the day of inspection, the Administrator tightened the clamps to secure the hose in place.

On 5/5/26, the facilities maintenance person replaced the clamps with a cord protector and secured the cord protector to the ground after verifying that the alarm still sounded when pressure was applied to the cord. See attached photo.

The Administrator or Operations Manager will verify that the alarm hose is secured to the ground at least monthly and as needed due to significant changes in the weather that could loosen the cord protector. The monthly checks will begin in June 2026.

The Administrator will conduct the home's next quality management review by 6/5/26. Documentation of the quality management review will be kept, including documentation of staff signing off as acknowledging and understanding expectations surrounding notifying management if they notice that the alarm hose is loose/a tripping hazard.

Licensee's Proposed Overall Completion Date: 06/05/2026

Implemented (█) - 06/03/2026

101j7 - Lighting/Operable Lamp

5. 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

At approximately 10:40 a.m., there was no operable bedside light or other source of lighting that could be turned on at bedside in resident room #8. There was no light bulb in the lamp.

Plan of Correction

Accept (█) - 05/12/2026

On 4/14/26, the day of inspection, the Operations Manager placed a new lightbulb into the bedside lamp, and ensured it was in working order, in bedroom #8.

101j7 Lighting/Operable Lamp (continued)

On 4/16/26 the Operations Manager completed a check of all other bedside lighting to ensure they were present and in working order. No deficiencies were noted.

On 5/11/26 the Director of Clinical Operations notified all staff via email that beginning on the week of 5/18/26, staff will be instructed to check the function of bedside light sources once daily and document the check in the electronic MAR as part of the resident equipment safety checks. If a bedside light is found inoperable at the time of the check, staff will change the bulb and/or alert the Operations Manager to replace it if it is non functional. See attached email.

The Administrator will conduct the home's next quality management review by 6/5/26. Documentation of the quality management review will be kept, including documentation of staff signing off as acknowledging and understanding expectations surrounding bedside lighting.

Licensee's Proposed Overall Completion Date: 06/05/2026

Implemented (█) - 06/03/2026

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

6. Requirements

- 2600.
- 102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

At 1:15 p.m., there was no grab bar, hand rail or assist bar for the toilet in the staff bathroom located on the lower level of the home.

Plan of Correction

Accept (█) - 05/12/2026

On 4/21/26 the facilities maintenance person installed a hand rail to the right of the toilet in the staff bathroom. See attached photo.

On 4/21/26 the Administrator checked all bathrooms and confirmed that a grab bar was available in all toilet and bathing areas.

Beginning in June 2026, the home's Health & Safety Representative will check to ensure all grab bars in toilet and bathing areas remain in place and are secure, during their routine walk throughs/inspections.

The Administrator will conduct the home's next quality management review by 6/5/26. Documentation of the quality management review will be kept, including documentation of staff signing off as acknowledging and understanding expectations surrounding ensuring all grab bars remain secure.

Licensee's Proposed Overall Completion Date: 06/05/2026

Implemented (█) - 06/03/2026

126a - Furnace Inspection

7. Requirements

126a - Furnace Inspection (continued)

2600.

126.a. A professional furnace cleaning company or trained maintenance staff person shall inspect furnaces at least annually. Documentation of the inspection shall be kept.

**Description of Violation**

*The most recent furnace inspection was conducted on 2/4/25.*

**Plan of Correction**

**Accept (█ - 05/12/2026)**

*On 4/14/26 the Administrator contacted █ Services to confirm that an annual service agreement was in place. On 4/15/26 a representative from █ Services stated that there was not a current annual service agreement on file. On 4/15/26 the Director of Clinical Operations signed an HVAC annual service agreement with █ Services (see attached).*

*On 5/12/26 the Director of Clinical Operations received confirmation that payment to █ Services has occurred, and an appointment was scheduled to occur on 5/18/26.*

*The Operations Manager will maintain a record of completed furnace maintenance to ensure inspections are completed annually.*

**Licensee's Proposed Overall Completion Date: 06/05/2026**

**Implemented (█ - 06/03/2026)**

132f - Alternate Exit Routes

**8. Requirements**

2600.

132.f. Alternate exit routes shall be used during fire drills.

**Description of Violation**

*According to the home's fire drill records, the kitchen exit was the only exit used for all fire drills from 3/31/25 through 3/27/26 except for the following dates: 3/31/25, 9/6/25, and 3/27/26.*

**Plan of Correction**

**Accept (█ - 05/12/2026)**

*On 4/27/26 the Administrator completed an overnight fire drill simulating a kitchen fire that would block access to the kitchen exit. All residents/staff in the home when the alarm sounded successfully evacuated using the Activity Room exit, within the home's allotted evacuation time. See attached copy of completed fire drill form.*

*On 5/8/26 the Administrator emailed the home's Health & Safety Representative, re-educating that alternate exit routes shall be used during fire drills, and that the same exit route cannot be repeated more than twice in a row. See attached email, with response from the H&S Rep acknowledging understanding of expectation.*

*The Administrator will audit and review the completed fire drill forms monthly. If an exit is used more than twice in a row, an additional drill be conducted as soon as possible simulating a fire which blocks that exit to ensure all residents and staff are familiar with all exit routes in case of an emergency.*

*The Administrator will conduct the home's next quality management review by 6/5/26. Documentation of the quality management review will be kept, including documentation of staff signing off as acknowledging and understanding expectations surrounding using all available exit routes during fire drills, based on the location of the simulated fire.*

132f - Alternate Exit Routes (continued)

Licensee's Proposed Overall Completion Date: 06/05/2026

Implemented ( ) - 06/03/2026

184a - Resident's Meds Labeled

9. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #1 is prescribed [redacted] AND [redacted] However, at 2:40 p.m., the pharmacy label for this medication indicated [redacted]

Resident #1 is prescribed [redacted] AND [redacted] However, the pharmacy label for this medication indicated [redacted]

Plan of Correction

Accept ( ) - 05/12/2026

On 4/14/26, the day of inspection, the home's RN applied temporary "Directions Changed, Refer to MAR" stickers to Resident #1's [redacted]. The home's LPN also contacted the pharmacy to request new labels that match the order on the MAR. These were received the same evening, on 4/14/26, and applied to the medications.

By 5/21/26, the LPN will audit all resident medications and treatments to ensure the label and MAR match exactly.

The Medication Manager will check all resident medications and treatments to ensure the label and MAR match exactly at least monthly and as needed. The Medication Manager will work with the pharmacy to fix any discrepancies immediately. Documentation of these audits will be kept.

The Administrator will randomly audit at least one medication or treatment per resident monthly to ensure the label and MAR match exactly. This audit will begin in June.

The Administrator will conduct the home's next quality management review by 6/5/26. Documentation of the quality management review will be kept, including documentation of staff signing off as acknowledging and understanding expectations surrounding steps to be taken if it is found that a medication or treatment label does not match the order in the MAR exactly.

Licensee's Proposed Overall Completion Date: 06/05/2026

Implemented ( ) - 06/03/2026

187a - Medication Record

10. Requirements

2600.

187a Medication Record (continued)

- 187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
  - 4. Strength.
  - 8. Frequency of administration.

**Description of Violation**

Resident #3 is prescribed [REDACTED]. However, at 2:15 p.m., the resident's April 2016 medication administration record (MAR) for this medication indicated [REDACTED]. The MAR did not have the strength of the medication written in the same numerical format as the order.

**Plan of Correction**

Accepted ( [REDACTED] ) - 05/12/2026

On 4/14/26, the day of inspection, the home's RN applied "Directions Changed, Refer to MAR" stickers to Resident #3's [REDACTED]

On 5/1/26 a new order for Resident #3's [REDACTED] was delivered with updated instructions: [REDACTED]. The concentration listed on the MAR as [REDACTED] matches the label exactly.

By 5/21/26, the LPN will audit all resident medications and treatments to ensure the label and MAR match exactly.

The Medication Manager will check all resident medications and treatments to ensure the label and MAR match exactly at least monthly and as needed. The Medication Manager will work with the pharmacy to fix any discrepancies immediately. Documentation of these audits will be kept.

The Administrator will randomly audit at least one medication or treatment per resident monthly to ensure the label and MAR match exactly. This audit will begin in June.

The Administrator will conduct the home's next quality management review by 6/5/26. Documentation of the quality management review will be kept, including documentation of staff signing off as acknowledging and understanding expectations surrounding steps to be taken if it is found that a medication or treatment label does not match the order in the MAR exactly.

Licensee's Proposed Overall Completion Date: 06/05/2026

Implemented ( [REDACTED] ) - 06/03/2026

187b - Date/Time of Medication Admin.

**11. Requirements**

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

**Description of Violation**

Resident #4 is prescribed [REDACTED]. The home obtained a waiver from the Department to allow non licensed staff to administer this [REDACTED] medication. The home has checks in place to ensure that a medically licensed staff person administers the medication at least twice weekly per waiver requirement. On 4/10/26, staff person C, a medication technician, administered the medication to resident #4. However, due to the checks in place, [REDACTED] the

187b - Date/Time of Medication Admin. (continued)

manager on duty, entered staff person C's initials onto the electronic MAR indicating that the medication had been administered.

**Plan of Correction**

Accept (█ - 05/12/2026)

For the remainder of the business week, the home's RN or LPN administered the █ for Resident#4.

On 4/20/26, a new staff role of "Caregiver █" was added to the electronic MAR. All unlicensed staff that have completed the required additional training as mandated by the waiver, will be able to document their administration of the █ under this role.

█ trained staff were emailed on 4/20/26 by the Administrator (see attached) that they must continue to text the on-call person to ask permission before administering the █ to ensure compliance with the waiver, which includes that the RN/LPN must administer the █ at least twice a week if they are on site. A MAR entry reminding staff to contact the on-call to ask permission before administering the █ was already in place and will continue.

The Administrator will conduct the home's next quality management review by 6/5/26. Documentation of the quality management review will be kept, including documentation of staff signing off as acknowledging and understanding expectations surrounding this new process.

Licensee's Proposed Overall Completion Date: 06/05/2026

Implemented (█ - 06/03/2026)