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

August 12, 2026

[redacted] AREA DIRECTOR OF OPERATIONS
WASHINGTON OPS LLC
[redacted]

RE: HAWTHORNE WOODS AL
791 LOCUST AVENUE
WASHINGTON, PA, 15301
LICENSE/COC#: 45409

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/04/2026, 05/05/2026, 05/11/2026 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: *HAWTHORNE WOODS AL* **License #**: *45409* **License Expiration**: *10/31/2026*

Address: *791 LOCUST AVENUE, WASHINGTON, PA 15301*

County: *WASHINGTON* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *WASHINGTON OPS LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *03/16/1999* **Issued By**: *Dept. of Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *90* **Waking Staff**: *68*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *05/11/2026*

Inspection Dates and Department Representative

05/04/2026 - On-Site: [redacted]

05/05/2026 - On-Site:

05/11/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *81* **Residents Served**: *69*

Special Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *69*

Diagnosed with Mental Illness: *9* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *21* **Have Physical Disability**: *0*

Inspections / Reviews

05/04/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/27/2026*

Inspections / Reviews *(continued)*

06/29/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/31/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *07/06/2026*

07/13/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/31/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/05/2026*

08/12/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/31/2026*

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

18 Other laws, regs, ordins.

1. Requirements

2800.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted on 9/23/2016, requires carbon monoxide detectors to be installed in close proximity of, but not less than 15 feet from any fossil fuel burning device or appliance. On 5/4/2026 at 12:06pm, no carbon monoxide alarm was present in close proximity to the gas dryer located in the residence's 2nd floor laundry room.

Repeated Violation - 7/31/2025; 5/5/2025, et al.

Plan of Correction ***Directed (- 07/10/2026)***

Immediate Corrective Action:

On the first day of the survey, the Executive Director, installed a carbon monoxide detector in the second-floor laundry room in accordance with the Care Facility Carbon Monoxide Alarms Standards Act and regulatory requirements.

Preventative Action:

The Executive Director initiated a building-wide audit of all carbon monoxide detectors and fossil fuel-burning appliances. The audit began on 6/18/2026 and will be completed within 24 hours of receipt of the revised Plan of Correction to verify all carbon monoxide detectors are installed in the required locations and all fossil fuel-burning appliances are appropriately protected.

On 6/18/2026, , Executive Director Specialist, educated the Executive Director on Regulation 18, the Care Facility Carbon Monoxide Alarms Standards Act, and the residence's Environmental Safety Policy.

The Executive Director updated the monthly environmental safety inspection process to include verification of all carbon monoxide detectors and fossil fuel-burning appliances.

Compliance Monitoring:

Beginning on 7/1/2026, the Executive Director or designee will complete monthly environmental safety audits for 3 months to verify continued compliance with carbon monoxide detector placement and environmental safety requirements.

Findings will be reviewed and discussed during the monthly Quality Assurance meeting for three months. The Quality Assurance meeting will be attended by the Executive Director, Health and Wellness Director, Care Team Manager, Business Office Coordinator, Sales Director, Life Engagement Manager. Corrective action will be taken immediately regarding any identified concerns.

Proposed Overall Completion Date: 08/26/2026

18 Other laws, regs, ordins. (continued)

DIRECTED: The Quality Assurance meeting will be held no later than 7/31/2026, and documentation will be kept.
[redacted] 7.13.26

Directed Completion Date: *07/31/2026*

Implemented ([redacted] - 08/10/2026)

20b7 No POA/Guardianship

2. Requirements

2800.
20.b. If the residence provides assistance with financial management or holds resident funds, the following requirements apply:
7. The legal entity, administrator and staff persons of the residence are prohibited from being assigned power of attorney or guardianship of a resident or a resident's estate.

Description of Violation

Staff person A, the residence's Life Enrichment Coach, was assigned as resident #1's Power of Attorney that includes financial management on [redacted]

Plan of Correction ***Directed ([redacted] - 07/13/2026)***

Immediate Corrective Action:

Upon discovery of the deficient practice, Human Resources immediately suspended Staff Member A pending receipt of documentation verifying removal as the resident's Power of Attorney. The Executive Director reviewed Resident #1's record, obtained documentation from the resident's attorney verifying Staff Member A was no longer serving as the resident's Power of Attorney, and placed the documentation in the resident's record on 6/15/2026.

Preventative Action:

The Executive Director initiated a 100% audit of all resident records on 6/18/2026 to verify that no employee, administrator, or representative of the residence is designated as a resident's Power of Attorney or guardian. The audit remains in progress and will be completed by 6/23/2026.

On 6/18/2026, Executive Director Specialist, educated the Executive Director on Regulation 20(b)(7) and the residence's policy regarding resident financial management and prohibited employee relationships.

On 6/18/2026, the Executive Director updated the admission and resident record review process to include verification of legal representatives during the admission process and routine record reviews.

Compliance Monitoring:

Beginning on 7/1/2026, the Executive Director or designee will conduct monthly audits of resident records for three months to verify ongoing compliance.

Findings will be reviewed and discussed during the monthly Quality Assurance meeting for three months. The Quality Assurance meeting will be attended by the Executive Director, Health and Wellness Director, Care Team Manager, Business Office Coordinator, Sales Director, Life Engagement Manager, and Maintenance. Corrective

20b7 No POA/Guardianship (continued)

action will be taken immediately for any identified concerns.

Proposed Overall Completion Date: 08/26/2026

DIRECTED: The Quality Assurance meeting will be held no later than 7/31/2026, and documentation will be kept. [redacted] *7.13.26*

Directed Completion Date: *07/31/2026*

Implemented ([redacted] - 08/10/2026)

25b Contract signatures and renewal

3. Requirements

2800.

25b . 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. The contract must run month-to-month with automatic renewal unless terminated by the resident with 14 days notice or by the residence with 30 days notice in accordance with § 2800.228 (relating to transfer and discharge).

Description of Violation

Resident #2's resident-residence contract, dated [redacted] *, was not signed by the resident.*

Resident #3's resident-residence contract, dated [redacted] *, was not signed by the resident.*

Plan of Correction ***Directed ([redacted] - 07/13/2026)***

Immediate Corrective Action:

The Executive Director reviewed the resident contracts for Resident #2 and Resident #3 on 6/18/2026. Corrective action was immediately initiated, and the required resident signatures were obtained. The resident contracts were updated to reflect compliance with Regulation 25(b).

Preventative Action:

The Executive Director initiated a 100% audit of all resident contracts on 6/18/2026,to verify that all required signatures are present. The audit was completed on 6/26/2026.

On 6/18/2026, Executive Director Specialist, educated the Executive Director on Regulation 25(b) and the Resident Admission Agreement Policy.

On 6/18/2026, the Executive Director implemented a contract review checklist to ensure all required signatures are obtained and verified prior to completion of the admission process and upon execution of updated resident contracts.

Compliance Monitoring:

Beginning on 7/1/2026, the Executive Director or designee will complete monthly audits of resident contracts for three months to verify ongoing compliance.

Findings will be reviewed and discussed during the monthly Quality Assurance meeting for three months. The

25b Contract signatures and renewal (continued)

Quality Assurance meeting will be attended by the Executive Director, Health and Wellness Director, Care Team Manager, Business Office Coordinator, Sales Director, Life Engagement Manager. Corrective action will be taken immediately regarding any identified concerns.

Proposed Overall Completion Date: 08/26/2026

DIRECTED: The Quality Assurance meeting will be held no later than 7/31/2026, and documentation will be kept. [redacted] 7.13.26

Directed Completion Date: *07/31/2026*

Implemented ([redacted] - 08/12/2026)

57c 2 hrs/day/immob. resident

4. Requirements

2800.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On 4/19/2026, there were 69 residents in the residence, including 21 residents with mobility needs, requiring a total minimum of 90 hours of direct care service. On this date, only 80.25 hours of direct care staffing was provided.

On 4/25/2026, there were 69 residents in the residence, including 21 residents with mobility needs, requiring a total minimum of 90 hours of direct care service. On this date, only 78 hours of direct care staffing was provided.

Plan of Correction ***Directed ([redacted] - 07/13/2026)***

Immediate Corrective Action:

The Executive Director and Care Team Manager (CTM) reviewed the staffing schedules on 6/18/2026 and adjusted caregiver assignments and staffing hours as needed to ensure required direct care staffing hours were scheduled based on resident census and resident mobility needs.

Preventative Action:

On 6/18/2026 Executive Director Specialist, educated the Executive Director and Care Team Manager on Regulation 57(c) and the Resident Staffing Policy.

The Executive Director implemented a daily staffing calculation worksheet on 6/18/2026. The daily staffing calculation worksheet will be completed by the Care Team Manager prior to publishing each weekly staffing schedule and whenever resident census or resident mobility needs change. The worksheet will be used to verify that required direct care staffing hours are scheduled in accordance with Regulation 57(c).

Compliance Monitoring:

Beginning on 7/1/2026, the Executive Director and Care Team Manager will review staffing calculations and staffing schedules weekly to verify compliance with Regulation 57(c). Findings will be reviewed and discussed during the monthly Quality Assurance meeting for three months.

57c 2 hrs/day/immob. resident (continued)

The Quality Assurance meeting will be attended by the Executive Director, Health and Wellness Director, Care Team Manager, Business Office Coordinator, Sales Director, Life Engagement Manager.. Corrective action will be taken immediately for any identified concerns.

Proposed Overall Completion Date: 08/26/2026

DIRECTED: The Quality Assurance meeting will be held no later than 7/31/2026, and documentation will be kept. [redacted] 7.13.26

Directed Completion Date: *07/31/2026*

Implemented ([redacted] - 08/10/2026)

57d Waking staff hours

5. Requirements

2800.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 4/19/2026, 69 residents were present in the residence including 21 residents with mobility needs, requiring a total minimum of 67.5 direct care hours during waking hours; however, only 66 direct care hours were provided during waking hours.

On 4/25/2026, 69 residents were present in the residence including 21 residents with mobility needs, requiring a total minimum of 67.5 direct care hours during waking hours; however, only 59.5 direct care hours were provided during waking hours.

Plan of Correction ***Directed ([redacted] - 07/13/2026)***

Immediate Corrective Action:
The Executive Director and Care Team Manager (CTM) reviewed the staffing schedules on 6/18/2026 and adjusted caregiver assignments and staffing hours as needed to ensure at least 75% of the required direct care staffing hours were scheduled during waking hours based on resident census and resident mobility needs.
Preventative Action:
On 6/18/2026, Executive Director Specialist, educated the Executive Director and Care Team Manager on Regulation 57(d) and the Resident Staffing Policy.
The Executive Director updated the daily staffing calculation worksheet on to include verification that at least 75% of required direct care staffing hours are scheduled during waking hours. The staffing calculation worksheet will be completed by the Executive Director and Care Team Manager prior to publishing each weekly staffing schedule and whenever resident census or resident mobility needs change. The worksheet will be used to verify compliance with Regulation 57(d) before staffing schedules are finalized.
Compliance Monitoring:
Beginning on 7/1/2026, the Care team Manager will review staffing calculations and staffing schedules weekly to verify compliance with Regulation 57(d). Findings will be reviewed and discussed during the monthly Quality Assurance meeting for three months.
The Quality Assurance meeting will be attended by the Executive Director, Health and Wellness Director, Care Team Manager, Business Office Coordinator, Sales Director, Life Engagement Manager. Corrective action will be taken

57d Waking staff hours (continued)

immediately for any identified concerns.

Proposed Overall Completion Date: 08/26/2026

DIRECTED: The Quality Assurance meeting will be held no later than 7/31/2026, and documentation will be kept. [redacted] 7.13.26

Directed Completion Date: *07/31/2026*

Implemented ([redacted] - 08/10/2026)

81b Resident equip – good repair

6. Requirements

2800.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 5/4/2026, at 12:23 pm, resident #4's bedside mobility device was not securely attached to the bedside and moved back and forth freely about 1 inch.

Plan of Correction ***Directed ([redacted] - 07/13/2026)***

Immediate Corrective Action:
The Executive Director and Health and Wellness Director (HWD) reviewed the identified bedside mobility device on 6/18/2026. The bedside mobility device was properly secured to the bed frame in accordance with the manufacturer's instructions to eliminate movement and ensure resident safety.
Preventative Action:
The Health and Wellness Director initiated a residence-wide audit of all resident mobility equipment on 6/18/2026. The audit of all bedside mobility equipment will be completed within 48 hours of receipt of the revised Plan of Correction to verify all equipment is clean, secure, in good repair, and free of hazards.
On 6/18/2026, Executive Director Specialist, educated the Care Team Manager (CTM), Health and Wellness Director (HWD), and direct care staff on Regulation 81(b) and the Resident Equipment Safety Policy. Staff were re-educated on promptly reporting equipment concerns to leadership for immediate follow-up.
Compliance Monitoring:
Beginning on 7/1/2026, the Care Team Manager and Health and Wellness Director will complete monthly audits of resident mobility equipment to verify continued compliance with Regulation 81(b).
Findings will be reviewed and discussed during the monthly Quality Assurance meeting for three months. The Quality Assurance meeting will be attended by the Executive Director, Health and Wellness Director, Care Team Manager, Business Office Coordinator, Sales Director, Life Engagement Manager. Corrective action will be taken immediately regarding any identified concerns.

Proposed Overall Completion Date: 08/26/2026

DIRECTED: The Quality Assurance meeting will be held no later than 7/31/2026, and documentation will be kept. [redacted] 7.13.26

81b Resident equip – good repair *(continued)*

Directed Completion Date: *07/31/2026*

Implemented (- 08/10/2026)

127a Portable space heaters

7. Requirements

2800.
127.a. Portable space heaters are prohibited.

Description of Violation

On 5/5/2026 at approximately 11:35 am, there was a portable space heater in use in resident living unit # 128.

Plan of Correction ***Directed (- 07/13/2026)***

Immediate Corrective Action:
The portable space heater located in Resident Room #128 was immediately removed from service and removed from the resident living unit by the Executive Director on the date it was identified during the licensing survey.
Preventative Action:
On 6/18/2026, the Executive Director inspected the residence and, in collaboration with the Health and Wellness Director (HWD) and Care Team Manager (CTM), initiated a residence wide environmental safety audit. The audit of all resident rooms and common areas will be completed within 48 hours of receipt of the revised Plan of Correction to verify that no portable space heaters are present within the residence.
On 6/18/2026, Executive Director Specialist, educated staff on Regulation 127(a) and the residence's Environmental Safety Policy regarding the prohibition of portable space heaters.
The Executive Director added verification that no portable space heaters are present to the monthly environmental safety inspection process.
Compliance Monitoring:
Beginning on 7/1/2026, the Executive Director or designee will complete monthly environmental safety audits to verify continued compliance with Regulation 127(a).
Findings will be reviewed and discussed during the monthly Quality Assurance meeting for three months. The Quality Assurance meeting will be attended by the Executive Director, Health and Wellness Director, Care Team Manager, Business Office Coordinator, Sales Director, Life Engagement Manager. Corrective action will be taken immediately regarding any identified concerns.

Proposed Overall Completion Date: 08/26/2026

DIRECTED: The Quality Assurance meeting will be held no later than 7/31/2026, and documentation will be kept. 7.13.26

Directed Completion Date: *07/31/2026*

Implemented (- 08/10/2026)

132f Alternate exit routes

8. Requirements

2800.
132.f. Alternate exit routes shall be used during fire drills.

132f Alternate exit routes *(continued)*

Description of Violation

According to the fire drill log, the residence used the exit route "Y to R" for the drills held on: 4/30/2026, 3/31/2026, 2/27/2026, 1/30/2026, 12/31/2025, and 11/26/2025.

Plan of Correction ***Directed (- 07/13/2026)***

IImmediate Corrective Action:
The Executive Director reviewed the fire drill program and fire drill documentation on 6/18/2026 to ensure future fire drills utilize alternating exit routes and accurately document the routes used during each drill.
Preventative Action:
On 6/18/2026,Executive Director Specialist, educated the Executive Director on Regulation 132(f) and the residence's Fire Drill Policy.
The Executive Director and Maintenance Designee are responsible for planning and conducting all fire drills. The Executive Director reviewed the existing fire drill tracking log on 6/18/2026. The fire drill tracking log documents the date, time, shift, exit routes utilized, staff participation, and drill outcomes. Prior to each scheduled fire drill, the Executive Director will review the fire drill tracking log to ensure alternate exit routes are rotated and documented appropriately. The Yellow and Red exit routes will be alternated during fire drills to ensure continued compliance with Regulation 132(f).
Compliance Monitoring:
Beginning on 7/1/2026, the Executive Director will review fire drill documentation monthly to verify alternate exit routes are utilized and documented appropriately.
Findings will be reviewed and discussed during the monthly Quality Assurance meeting for three months. The Quality Assurance meeting will be attended by the Executive Director, Health and Wellness Director, Care Team Manager, Business Office Coordinator, Sales Director, Life Engagement Manager. Corrective action will be taken immediately regarding any identified concerns.

Proposed Overall Completion Date: 08/26/2026

DIRECTED: The Quality Assurance meeting will be held no later than 7/31/2026, and documentation will be kept. 7.13.26

Directed Completion Date: *07/31/2026*

Implemented (- 08/10/2026)

144d Smoking outside

9. Requirements

2800.
144.d. Smoking outside of the smoking room is prohibited.

Description of Violation

On 5/4/2026 at 11:55 am, there were approximately 11 cigarette butts on the ground outside by the courtyard area which is not the residence's designated smoking area. According to the residence's rules, the residence's designated smoking area is the inside smoking room.

Plan of Correction ***Directed (- 07/13/2026)***

Immediate Corrective Action:
Housekeeping removed the cigarette butts identified in the courtyard area on the day of the licensing survey.

144d Smoking outside (continued)

Preventative Action:
On 6/18/2026, the Executive Director inspected the courtyard and all outdoor areas and initiated ongoing monitoring of the designated smoking area. The Executive Director and Care Team Manager (CTM) are responsible for ongoing monitoring to ensure residents utilize the designated smoking area and comply with the residence's smoking policy.
On 6/18/2026, staff were educated on Regulation 144(d) and the Resident Smoking Policy. Staff were instructed to immediately redirect any resident observed smoking outside the designated smoking area and notify the Executive Director of repeated noncompliance for appropriate follow-up.
Compliance Monitoring:
Beginning on 7/1/2026, the Executive Director or designee will complete monthly environmental audits to verify continued compliance with Regulation 144(d).
Findings will be reviewed and discussed during the monthly Quality Assurance meeting for three months. The Quality Assurance meeting will be attended by the Executive Director, Health and Wellness Director, Care Team Manager, Business Office Coordinator, Sales Director, Life Engagement Manager. Corrective action will be taken immediately regarding any identified concerns.

Proposed Overall Completion Date: 08/26/2026

DIRECTED: The Quality Assurance meeting will be held no later than 7/31/2026, and documentation will be kept. [redacted] 7.13.26

Directed Completion Date: *07/31/2026*

Implemented ([redacted] - 08/10/2026)

227h Support plan – refusal sign

10. Requirements

2800.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident #5 participated in the development of [redacted] initial support plan on [redacted]. The resident did not sign the support plan and there is no indication on the support plan as to whether the resident refused to sign or was unable to sign.

Resident #6 participated in the development of [redacted] annual support plan on [redacted] The resident did not sign the support plan and there is no indication on the support plan as to whether the resident refused to sign or was unable to sign.

Plan of Correction ***Directed ([redacted] - 07/13/2026)***

Immediate Corrective Action:
The Health and Wellness Director reviewed the support plans for Resident #5 and Resident #6 on 6/18/2026 and updated the support plans to document whether the resident refused to sign or was unable to sign in accordance with Regulation 227(h).
Preventative Action:
The Health and Wellness Director initiated a 100% audit of all resident support plans on 6/18/2026 to verify

227h Support plan – refusal sign (continued)

resident signatures or documentation of refusal or inability to sign. The audit was completed on 6/23/2026.
On 6/18/2026, the Executive Director and Health and Wellness Director were educated on Regulation 227(h) and the Resident Support Plan Policy.
On 6/18/2026, the Health and Wellness Director revised the support plan review process to require verification of resident signatures or documentation of refusal or inability to sign prior to filing the support plan in the resident record.
Compliance Monitoring:
Beginning on 7/1/2026, the Health and Wellness Director will conduct monthly audits of resident support plans for four months to verify continued compliance with Regulation 227(h).
Findings will be reviewed and discussed during the monthly Quality Assurance meeting for four months. The Quality Assurance meeting will be attended by the Executive Director, Health and Wellness Director, Care Team Manager, Business Office Coordinator, Sales Director, Life Engagement Manager. Corrective action will be taken immediately regarding any identified concerns.

DIRECTED: The Quality Assurance meeting will be held no later than 7/31/2026, and documentation will be kept. [redacted] 7.13.26

Proposed Overall Completion Date: 08/26/2026

Directed Completion Date: *07/31/2026*

Implemented ([redacted] - 08/10/2026)