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

July 10, 2026

[redacted], QUALITY MANAGEMENT SPECIALIST
REMED RECOVERY CARE CENTERS LLC
[redacted]

RE: REMED RECOVERY CARE CENTERS
100 BRISTOL LANE
IRWIN, PA, 15642
LICENSE/COC#: 44997

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/21/2026 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: *REMED RECOVERY CARE CENTERS* **License #**: *44997* **License Expiration**: *06/14/2027*

Address: *100 BRISTOL LANE, IRWIN, PA 15642*

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

Administrator

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

Legal Entity

Name: *REMED RECOVERY CARE CENTERS LLC*

Address: [redacted]

Phone: **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *04/04/2019* **Issued By**: *Hempfield Twp.*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *13* **Waking Staff**: *10*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *05/21/2026*

Inspection Dates and Department Representative

05/21/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *8* **Residents Served**: *8*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *8* **Are 60 Years of Age or Older**: *2*

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

Have Mobility Need: *5* **Have Physical Disability**: *0*

Inspections / Reviews

05/21/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/15/2026*

06/16/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/10/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/24/2026*

Inspections / Reviews *(continued)*

06/24/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/10/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *07/10/2026*

07/10/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/10/2026*

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

82b - Poisonous Material Storage

1. Requirements

2600.
82.b. Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

Description of Violation

There was a 1 pound plastic container or Clorox Wipes, labeled "Call a poison control center for treatment advice", on the kitchen counter next to two 36 ounce containers of Thick It liquid thickener.

Plan of Correction ***Accept (- 06/24/2026)***

A posting was placed in the kitchen on 6/9/26, outlining that all poisonous materials must be stored separately and away from food and/or food preparation surfaces. This topic was addressed with an email to staff and a brief staff meeting on 6/10/26. A tracker was created and placed in the kitchen on 6/10/26 for staff to complete each shift that instructs them to ensure that all poisonous materials are properly stored and are not located in the food preparation area. Staff are instructed to initial on each shift and the program administrator will review this tracker each weekday to ensure compliance until there are 30 days without issue and then will check the tracker weekly from there on.

Updated:
On 5/21/26, the day of inspection, the Administrator immediately removed the canister of wipes from the counter and placed them in a secure location.
The posting placed in the kitchen on 6/9/26 was posted by the Administrator.
The email sent to all staff addressing this issue on 6/10/26 was sent by the Clinical Site Manager. Additionally, the Clinical Site Manager created the tracker for staff to document that there are no poisonous materials located in any food preparation areas, and that they are stored properly (see attached template). This tracker was implemented to begin on 6/10/26.
The tracker will be checked daily by the Administrator or a designee as noted above, and this will occur through at least 7/9/26 to ensure there are 30 days straight of compliance. Once 30 days is reached, the tracker will then switch to being completed on a weekly basis.

Licensee's Proposed Overall Completion Date: *06/17/2026*

Implemented (- 07/10/2026)

141b1 - Annual Medical Evaluation

2. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident # was admitted to the home on . However, the resident's most recent annual medical evaluation was completed on

Repeat Violation: 5/15/25

Plan of Correction ***Accept (- 06/16/2026)***

Medical Evaluation for the resident was immediately scheduled with the provider. It has since been completed (5/27/2026). See attached completed forms.
The Clinical Site Manager is responsible for ensuring that Medical Evaluation forms are completed timely and in their entirety. The Director of Clinical Operations reviewed these expectations with the Clinical Site Manager on 6/4/26

141b1 Annual Medical Evaluation (continued)

at our leadership meeting.
The House Supervisor/Administrator will complete an audit of the remaining resident Medical Evaluations to ensure they are completed entirely and within the required timeframe, by 6/19/26.
Going forward, the Administrator will complete quarterly audits of all DHS required paperwork for all residents. A complete audit will be completed by 6/30/26.

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

Implemented ([redacted] - 07/10/2026)

183b - Meds and Syringes Locked

3. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

There was a bottle of [redacted], unsecured, unattended and accessible in the top drawer of resident #2's bedside table.

Plan of Correction ***Accept ([redacted] - 06/16/2026)***

Procedures of administering [redacted] medications were reviewed with medication administration trained staff on 5/26/26 by the Administrator.
By 6/19/26 the clinical coordinator will audit all residents' medications and treatments to ensure they are available in the locked med cart, labeled and match the MAR exactly.
The Clinical Coordinator will check all resident medications and treatments to ensure they are available in the locked med cart, labeled and MAR match exactly at least monthly and as needed. The Clinical Coordinator will work with the pharmacy to fix any discrepancies immediately. Documentation of these audits will be kept monthly.
The Administrator will randomly audit at least one medication or treatment per resident monthly to ensure the medications are in the locked med cart, labeled and match the MAR exactly. This audit will begin in July.

Licensee's Proposed Overall Completion Date: *07/17/2026*

Implemented ([redacted] - 07/10/2026)

184a - Resident's Meds Labeled

4. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #2's [redacted] did not have a pharmacy label.

Plan of Correction ***Accept ([redacted] - 06/16/2026)***

184a - Resident's Meds Labeled (continued)

The day of the inspection Clinical Manager requested a label from the pharmacy and was received the same day, prior to the next administration of the medication at [redacted]
By 6/19/26 the clinical coordinator will audit all residents' medications and treatments to ensure they are labeled and match the MAR exactly.
The Clinical Coordinator will check all resident medications and treatments to ensure the label and MAR match exactly at least monthly and as needed. The Clinical Coordinator will work with the pharmacy to fix any discrepancies immediately.
Documentation of these audits will be kept monthly.
The Administrator will randomly audit at least one medication or treatment per resident monthly to ensure the medications are labeled and match the MAR exactly. This audit will begin in July.

Licensee's Proposed Overall Completion Date: *07/17/2026*

Implemented ([redacted] - 07/10/2026)

185a - Implement Storage Procedures

5. Requirements

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

Description of Violation

Resident #1 is prescribed [redacted] *. The resident's May 2026 medication administration record (MAR) indicates the resident's* [redacted]

Resident #2 is prescribed [redacted] *. However this medication was not available.*

Resident #3 is prescribed [redacted] *However, this medication was not available*

Plan of Correction ***Accept ([redacted] - 06/16/2026)***

The day of the inspection all unavailable medications were requested from the pharmacy and were receive the same day, prior to the next administration of the medication at [redacted]
The day of the inspection facility requested the pharmacy to update MAR to reflect [redacted] *for resident #1 which was updated immediately for staff* [redacted]
By 6/19/26 the clinical coordinator will audit all residents' medications and treatments to ensure they are available, labeled and match the MAR exactly.
The Clinical Coordinator will check all resident medications and treatments to ensure they are available labeled and MAR match exactly at least monthly and as needed. The Clinical Coordinator will work with the pharmacy to fix any discrepancies immediately.
Documentation of these audits will be kept monthly.
The Administrator will randomly audit at least one medication or treatment per resident monthly to ensure the

185a - Implement Storage Procedures (continued)

medications are labeled and match the MAR exactly. This audit will begin in July.

Licensee's Proposed Overall Completion Date: *07/17/2026*

Implemented (- 07/10/2026)

225a - Assessment 15 Days

6. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #4's initial assessment and support plan is not dated.

Plan of Correction ***Accept (- 06/24/2026)***

Resident #4 initial assessment was dated immediately at the time of the inspection. The House Supervisor/Administrator will complete an audit of the remaining residents' assessments to ensure they are completed entirely and within the required timeframe, by 6/19/26.
Going forward, the Administrator will complete quarterly audits of all DHS required paperwork for all residents. A complete audit will be completed by 6/30/26.

Updated:
Resident #4's assessment was dated on 5/21/26, the day of inspection, by the Case Manager (attached).
The Administrator will begin quarterly audits of all DHS required paperwork by 5/22/26, completing by 6/30/26, and will then conduct quarterly audits going forward.

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

Implemented (- 07/10/2026)

225c - Additional Assessment

7. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #2 had a verbal altercation with another resident on escalating to the other resident kicking resident #2 and knocking to the ground. Both resident's had a previous encounter on However, resident #2's annual assessment and support plan, dated indicates the resident has minimal problems with irritability, agitation and no problem with aggression and does not indicate any previous incidents or issues with the other resident.

Resident #3 had a verbal altercation with another resident on escalating to resident #3 kicking the other resident and knocking to the ground. Both resident's had a previous encounter on However, resident #3's annual assessment and support plan, dated indicates the resident has minimal problems with irritability,

225c - Additional Assessment (continued)

agitation and no problem with aggression, does not indicate any previous incidents or issues with the other resident and was not updated due to this significant change.

Plan of Correction ***Accept (- 06/24/2026)***

Both resident #2 & #3 had additional reassessments on 5/22/26 completed by Clinical Manager. RASP Change form was added to their charts to reflect the significant change. Annual assessment will reflect the change when they are due to be reassessed. Resident #2 due to be reassessed . Resident #3 due to be reassessed

Going forward any incident or significant change will be updated on a RASP change form and reflected on the residents annual assessment by the Clinical Manager & RCM.
The House Supervisor/Administrator will complete an audit of the remaining residents' assessments to ensure they are completed entirely and within the required timeframe, by 6/19/26.
Going forward, the Administrator will complete quarterly audits of all DHS required paperwork for all residents. A complete audit will be completed by 6/30/26.

Updated:
RASP change forms for both residents that were completed 5/22/26 are attached.
Going forward, any incident or significant change will be updated on a RASP change form within 5 calendar days.
The Administrator will begin quarterly audits of all DHS required paperwork by 5/22/26, completing by 6/30/26, and will then conduct quarterly audits going forward.

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

Implemented (- 07/10/2026)

227g -Support Plan Signatures

8. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #4's initial assessment and support plan is not signed by the resident or by the assessor.

Plan of Correction ***Accept (- 06/24/2026)***

Resident #4 initial assessment was signed immediately after the inspection. The House Supervisor/Administrator will complete an audit of the remaining residents' assessments to ensure they are completed entirely and within the required timeframe, by 6/19/26.
Going forward, the Administrator will complete quarterly audits of all DHS required paperwork for all residents. A complete audit will be completed by 6/30/26.

Updated:
Resident #4's assessment was dated on 5/21/26, the day of inspection, by the Case Manager (see previously attached).
The Administrator will begin quarterly audits of all DHS required paperwork by 5/22/26, completing by 6/30/26, and will then conduct quarterly audits going forward.

227g -Support Plan Signatures (continued)

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

Implemented (- 07/10/2026)

251c - Standardized Forms

9. Requirements

2600.
251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

Resident #2's annual medical evaluation, dated is not completed using the most recent Department medical evaluation form.

Resident #4's initial medical evaluation, dated is not completed using the most recent Department medical evaluation form.

Plan of Correction ***Accept (- 06/24/2026)***

On 6/3/2026, the clinical manager instructed the RCM to remove previous, outdated forms from electronic folders and download the current, the most up to date form for use with future evaluations.
As new forms are published, the Administrator will send an email out to notify management of the change and the above step will be completed to ensure consistent use of the most up to date forms.
The administrator, case manager, and/or clinical supervisor will complete semi annual checks to ensure that no information was missed and that the most up to date is currently being used for all clients.

Updated:
The Administrator or a designee will begin semi annual checks of all DHS required paperwork by 5/22/26, completing by 6/30/26, to ensure the most up to date form is being used.

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

Implemented (- 07/10/2026)