

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

July 1, 2026

[REDACTED] ADMINISTRATOR
CONCORDIA LUTHERAN MINISTRIES OF PITTSBURGH
125 BROWN ROAD
WEXFORD, PA, 15090

RE: CONCORDIA OF WEXFORD
125 BROWN ROAD
WEXFORD, PA, 15090
LICENSE/COC#: 44362

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/08/2026 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: *CONCORDIA OF WEXFORD* License #: *44362* License Expiration: *08/27/2026*
 Address: *125 BROWN ROAD, WEXFORD, PA 15090*
 County: *ALLEGHENY* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *CONCORDIA LUTHERAN MINISTRIES OF PITTSBURGH*
 Address: *125 BROWN ROAD, WEXFORD, PA, 15090*
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *03/15/1994* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *9* Total Daily Staff: *44* Waking Staff: *33*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal* Exit Conference Date: *06/08/2026*

Inspection Dates and Department Representative

06/08/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *56* Residents Served: *35*

Secured Dementia Care Unit
 In Home: *No* Area: Capacity: Residents Served:

Hospice
 Current Residents: *5*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *35*
 Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *0* Have Physical Disability: *1*

Inspections / Reviews

06/08/2026 Full
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *06/22/2026*

06/23/2026 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *06/29/2026*
 Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *06/29/2026*

Inspections / Reviews *(continued)*

07/01/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/29/2026

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

65e - 12 Hours Annual Training

1. Requirements

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person A has only completed 11 hours of training in the 2025 training year (1/1/25 – 12/31/25).

Direct care staff person B has only completed 11 hours of training in the 2025 training year (1/1/25 – 12/31/25).

Plan of Correction

Accept ([redacted]) - 06/23/2026

POC: On 6/9/2026, Staff person A and Staff person B were immediately retrained using the 2025 Medbridge training video for HIPAA, Compliance, and Ethics used by Concordia to educate Direct Care Staff. The training was completed by Administrator [redacted]. All Direct Care Staff will be educated on 2600.65e (Direct care staff persons shall have 12 hours of annual training relating to their job duties). The education will be presented by Administrator [redacted] and will be completed by June 23, 2026. A log of all staff 2026 annual mandatory training courses through Medbridge Training will be kept for each employee and the date the training was completed will be kept. Beginning on 7/1/26: The administrator/designee shall review all staff training documents at least quarterly to ensure documentation of all staff person training is present in accordance with 2600.65e. Audit records will be maintained and will be reviewed quarterly at the QA meeting, the next meeting scheduled for 8/12/2026. QA meeting minutes will also be maintained.

1. I respectfully dispute the violation issued under 2600.65.e (Direct care staff persons shall have 12 hours of annual training relating to their job duties). The violation was issued because Staff Person A and Staff Person B completed the January 2025 training modules (HIPAA, Compliance, and Ethics) on December 6, 2024. These trainings were completed early due to the implementation of a new learning management system and training program. At the time of implementation, the January 2025 training assignments had already been uploaded and made available to staff. The HIPAA, Compliance, and Ethics trainings completed on December 6, 2024, were designated as part of the facility's 2025 annual training plan and were intended to count toward the employees' required 12 hours of annual training for calendar year 2025. The training records clearly identify these courses as 2025 training requirements and demonstrate that Staff Person A and Staff Person B completed the assigned training in advance of the scheduled training month. The facility maintains that the intent and requirements of 2600.65(e) were met, as the employees completed the required job-related training and received credit toward their 2025 annual training hours. The training was not omitted; rather, it was completed ahead of schedule due to the transition to the new training platform. Both employees successfully completed at least 12 hours of job-related annual training designated for 2025. Therefore, I respectfully request that this violation be reconsidered and dismissed, as the training requirements were fulfilled and appropriately documented as part of the 2025 annual training program.

Licensee's Proposed Overall Completion Date: 06/23/2026

Implemented ([redacted]) - 07/01/2026

65g - Annual Training Content

2. 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:

65g - Annual Training Content (continued)

- 1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
- 3. Resident rights.

Description of Violation

Direct care staff person A, hired [REDACTED], did not receive required annual training for the 2025 training year to include:

- (1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
- (3) Resident rights.

Direct care staff person B, hired [REDACTED], did not receive required annual training for the 2025 training year to include:

- (1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
- (3) Resident rights.

REPEAT VIOLATION 6/12/25

Plan of Correction

Accepted ([REDACTED]) - 06/23/2026

On 6/9/2026, staff person A and B immediately received annual fire safe training by Administrator [REDACTED] who is the facility's fire safety trainer (certificate attached). All staff will be educated on 2600.65g (Annual Training Content) and Concordia policy #307 (Fire Drill). The staff training will be done by Administrator [REDACTED] and completed by June 27, 2026. A log of all facility staff and their date of annual fire training by a fire safety expert will be kept. Beginning on 7/1/26: The administrator/designee shall review all staff training documents at least quarterly to ensure all direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers receive training on all topics specified in 2600.65g during each training year. Documentation of all staff person trainings shall be kept in accordance with 2600.65i. Audit records will be maintained and will be reviewed quarterly at the QA meeting, next meeting scheduled for 8/12/2026. QA meeting minutes will also be maintained.

Licensee's Proposed Overall Completion Date: 06/23/2026

Implemented ([REDACTED]) - 07/01/2026

85a - Sanitary Conditions

3. Requirements

- 2600.
- 85.a. Sanitary conditions shall be maintained.

Description of Violation

At approximately 10:35 a.m., there were no paper towels at the sink of the first-floor bathroom to the left of the common library.

Plan of Correction

Accepted ([REDACTED]) - 06/23/2026

On 6/8/2026 the Housekeeper, [REDACTED], immediately changed the paper towels. All staff will be retrained on 2600.85a. (Sanitary conditions shall be maintained). The education will be completed by Administrator [REDACTED]. Training will be completed by 6/23/2026. A weekly audit of the paper towel dispensers will begin on 7/1/2026 and continue for 6 months and monthly thereafter. Audit will be completed by management/designee, and the audit log will be submitted to the administrator monthly who will log the information. Audit records will be maintained and will be reviewed quarterly at the QA meeting, the next meeting scheduled for 8/12/2026. QA

85a Sanitary Conditions (continued)

meeting minutes will also be maintained.

Licensee's Proposed Overall Completion Date: 06/23/2026

Implemented (█) - 07/01/2026

121a - Unobstructed Egress

4. Requirements

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

At approximately 9:50 a.m., the gate to the white picket fence blocked egress from the home's back courtyard side, the gate was locked with a latch out of view on the opposite side of the fence and could not be opened without reaching over the fence to undo the latch.

Plan of Correction

Accept (█) - 06/23/2026

POC: Immediately upon identification of the violation, the latch securing the gate located on the left side of the courtyard adjacent to the white picket fence was removed and replaced with a code compliant latch mechanism that is clearly visible and readily operable from the courtyard side without requiring an individual to reach over the fence. The gate now allows unobstructed egress from the courtyard area at all times. Maintenance personnel and department managers will receive education regarding the requirements of 2600.121(a), including maintaining all egress routes in a manner that permits immediate and unrestricted exit during an emergency. Education presented by Administrator, █ Education will be completed by 6/23/26. Beginning on 7/1/2026 the Maintenance Director/designee will conduct monthly environmental and safety inspections to verify that all exits, gates, passageways, and egress routes remain unlocked, unobstructed, and readily operable from the side of egress. Any deficiencies identified during inspections will be corrected immediately. Audit records will be maintained and will be reviewed quarterly at the QA meeting, next meeting scheduled for 8/12/2026. QA meeting minutes will also be maintained.

I respectfully dispute the violation issued under 2600.121(a), which states that stairways, hallways, doorways, passageways, and egress routes from rooms and from the building must be unlocked and unobstructed. The violation was issued because the gate located to the left side of the courtyard, adjacent to the white picket fence, was secured with a latch that was not visible from the courtyard side and could not be opened without reaching over the fence. I respectfully dispute this violation because the referenced gate is not designated, utilized, or identified as an exit or egress route for residents, staff, or visitors. This gate is not included on the home's emergency evacuation plans, fire evacuation maps, or designated means of egress. The home's approved evacuation route from the courtyard is through the gate located on the right side of the courtyard, which remains unobstructed and is equipped with a visible, readily accessible latch that allows immediate exit. At all times, the designated egress route from the courtyard was accessible, unobstructed, and compliant with evacuation procedures. The gate cited during the inspection serves as a boundary access point rather than an emergency exit and is not relied upon for resident evacuation or emergency egress. Based on the fact that the cited gate is not a designated egress route and that all required evacuation routes remained accessible and functional, I respectfully request reconsideration and removal of this violation.

Licensee's Proposed Overall Completion Date: 06/23/2026

Implemented (█) - 07/01/2026

127a - Portable Space Heaters

5. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

At approximately 10:05 a.m., there were three portable space heaters found stored within the ground floor furnace room.

Plan of Correction

Accept (█) - 06/23/2026)

Upon identification during the inspection, the three portable space heaters that were being stored in the ground floor furnace room were immediately removed from the home. The space heaters were not in use; however, they were removed to ensure compliance with regulatory requirements prohibiting portable space heaters on the premises. The Administrator, █ will review regulation 2600.127.a. (Portable space heaters are prohibited) with department managers and maintenance personnel by 6/23/26. Staff were instructed that portable space heaters are prohibited within the personal care home and may not be stored or utilized anywhere within the facility. The Maintenance Director/designee will conduct monthly rounds for 3 months and quarterly thereafter, beginning on 7/1/26, to ensure portable space heaters are not present within the facility. Any prohibited items identified during inspections will be removed immediately. Audit records will be maintained and will be reviewed quarterly at the QA meeting, next meeting scheduled for 8/12/2026. QA meeting minutes will also be maintained.

Licensee's Proposed Overall Completion Date: 06/23/2026

Implemented (█) - 07/01/2026)

132g - Fire Drills Days/Times

6. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely held the three most recent consecutive sleeping hours fire drills on or around the same time of day as indicated:

- 3/27/26 at 4:00 a.m.*
- 9/30/25 at 4:00 a.m.*
- 3/31/25 at 4:30 a.m.*

Plan of Correction

Accept (█) - 06/23/2026)

POC: Department managers and maintenance personnel will be re-educated on 2600.132(g) (Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low) and Concordia Policy #307(Fire Drills). Education will be presented by Administrator, █ Education will be completed by 6/23/2026. A yearly fire drill schedule has been developed that includes all required shifts, including sleeping hours. Beginning 7/1/26 fire drill records will be reviewed monthly by the Administrator/designee to verify compliance. The Administrator or designee will audit fire drill documentation monthly for a period of 12 months to ensure sleeping-hour drills are completed as scheduled. Audit records will be maintained and will be reviewed quarterly at the QA meeting, next meeting scheduled for 8/12/2026. QA meeting minutes will also be maintained.

132g Fire Drills Days/Times (continued)

I respectfully dispute the violation issued under 2600.132(g) regarding the scheduling of fire drills. The regulation requires fire drills to be conducted on different days of the week, at different times of the day and night, and not routinely held when additional staff are present or when resident attendance is low. A review of our fire drill documentation demonstrates that the facility conducted drills on varying days and at varying times throughout the year. While two drills were conducted at approximately 4:00 a.m., the remaining drills were held at different times during both daytime and evening hours. The occurrence of two drills at the same overnight hour does not establish a routine practice, particularly when viewed in the context of the facility's overall fire drill schedule. Additionally, the purpose of the regulation is to ensure staff and residents are prepared to respond to emergencies under varying conditions. Our fire drill program accomplishes this objective by conducting drills across multiple shifts and days, providing staff with opportunities to demonstrate emergency preparedness under different circumstances. The facility did not intentionally schedule drills at times of increased staffing, nor were drills routinely conducted when resident attendance was low. The fire drill records support that drills were conducted throughout the year in a manner consistent with the intent of the regulation. Based on the facility's substantial compliance with the requirements of 2600.132(g), I respectfully request reconsideration and removal of this violation.

Licensee's Proposed Overall Completion Date: 06/23/2026

Implemented (█ - 07/01/2026)

227d - Support Plan Medical/Dental

7. Requirements

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #1 was admitted to █ services on █. However, resident #1's significant change support plan, dated █, did not include the care or the services to be provided by █.

Resident #2 was admitted to █ services on █. However, resident #2's significant change support plan, dated █, did not include the care or services to be provided by █.

REPEAT VIOLATION 6/12/25

Plan of Correction

Accept (█ - 06/23/2026)

POC: RASP updates were created for Resident 1 and Resident 2 to clearly identify the services provided by hospice and the services provided by facility staff for all applicable ADLs. Nurses will be re educated by 6/23/26 on 2600.227(d) and Concordia Policy #105. Beginning on 7/1/2026 the Resident Care Coordinator/designee will audit hospice resident care plans monthly for three months and quarterly thereafter to ensure responsibilities for ADLs and services are clearly identified. Audit records will be maintained and will be reviewed quarterly at the QA meeting, next meeting scheduled for 8/12/2026. QA meeting minutes will also be maintained.

I respectfully dispute the violation issued under 2600.227(d). The regulation requires that the resident's support plan document the medical, dental, vision, hearing, mental health, behavioral care services, or referrals that will be

227d - Support Plan Medical/Dental (continued)

made available to the resident when such services are determined to be necessary. At the time of the inspection, the support plans for Resident 1 and Resident 2 documented that hospice services were in place. Specifically, each support plan states that hospice Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) visit three times per week and additionally on an as-needed basis. Therefore, the support plans clearly identify the medical services available to each resident. In addition, the facility remains responsible for the residents' day-to-day care, monitoring, and oversight. Hospice services supplement the care provided by the home and are available to residents as documented in their support plans. The involvement of hospice nursing staff was accurately reflected in the support plans and demonstrates compliance with the requirement to document services available to the residents. Because the support plans specifically identified hospice nursing services, including the frequency of visits and availability of additional visits as needed, the facility believes it was in compliance with the requirements of 2600.227(d). I respectfully request that this violation be reconsidered and removed.

Licensee's Proposed Overall Completion Date: 06/23/2026

Implemented (█) - 07/01/2026)