pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **8651 CAREY LANE OPCO LLC**
LEGAL ENTITY

To operate **THE REMINGTON SENIOR LIVING**
NAME OF FACILITY OR AGENCY

Located at **8651 CARE LANE, PITTSBURGH, PA 15237**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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 **120**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 37**

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 **August 27,** **2026** until **August 27,** **2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **455590**

ISSUING OFFICER

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 628 – 04/23

Pennsylvania
Department of Human Services

Emailing Date: August 26, 2026

[redacted]
8651 Carey Lane OpCo LLC
[redacted]

RE: The Remington Senior Living
8651 Carey Lane
Pittsburgh, Pennsylvania 15237
License #: 455590

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspection on July 1, 2026, of the above facility, we have found that your facility is in substantial compliance with the regulations, set forth in 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), that can be adequately assessed at this time. The licensing inspector was unable to complete a full inspection because this is a new home.

In accordance with 55 Pa.Code § 2600.11(b) (relating to procedural requirements for licensure or approval of personal care homes) a re-inspection of your newly licensed facility will be conducted within 3 months of the effective date of this license. Complete compliance with all applicable regulations is required in order to maintain your license.

Your NEW license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

Facility Information

Name: *The Remington Senior Living* **License #:** *45559* **License Expiration:**

Address: *8651 Carey Lane, Pittsburgh, PA 15237*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

Name: [redacted]

Legal Entity

Name: *8651 Carey Lane OpCo LLC*

Addres: [redacted]

Phone: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date:** *03/18/2019* **Issued By:** *Township of McCandless*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *150* **Waking Staff:** *113*

Inspection Information

Type: *Partial* **Notice:** *Announced* **BHA Docket #:**

Reason: *Complaint, Incident, Change Legal Entity* **Exit Conference Date:** *07/01/2026*

Inspection Dates and Department Representative

07/01/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: **Residents Served:** *96*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *4th Floor* **Capacity:** *37* **Residents Served:** *35*

Hospice

Current Residents: *23*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *95*

Diagnosed with Mental Illness: *1*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *54*

Have Physical Disability: *1*

Inspections / Reviews

07/01/2026 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/22/2026*

07/22/2026 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/28/2026*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/28/2026*

07/30/2026 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/28/2026*

Reviewer: [redacted] **Follow-Up Type:** *Exception*

23a - Activities of Daily Living Assistance

1. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #4 resides in the home's secured dementia care unit (SDCU), which is located on the 4th floor. Resident #4's most recent assessment and support plan, dated [redacted]/25, indicates resident #4 requires total supervision while in the community and needs attendance when outside the community. On 6/29/26 at approximately 4:20pm, resident #4 eloped from the SDCU unattended and was found by police in a ravine near the home at approximately 6:20pm. Resident #4 was returned to the community with several scratches to resident #4's right arm.

Plan of Correction ***Directed [redacted] - 07/22/2026)***

Upon discovery of the resident's absence, the community immediately initiated its missing resident/elopement protocol, including a thorough search of the building and grounds, notification of local law enforcement, the residents responsible party and applicable regulatory agencies.

The resident was taken to the local emergency room upon return to ensure there were no injuries or adverse effects from the incident.

On 6/30/2026, the Health Care Director reviewed resident #4's RASP and updated it to include additional individualized interventions to reduce the risk of future elopement.

Starting 6/29/2026, upon return from the hospital, a one to one was initiated with resident #4 and continued through 7/6/2026. This was provided by Remington staff.

On 7/1/2026, the Healthcare Director completed a review of current Memory care resident's assessments to identify any residents at risk for elopement.
Residents identified as having an elopement risk had their care plans reviewed and revised, as needed, to ensure supervision levels and interventions accurately reflected their current needs. Documentation shall be maintained.

On, 6/29/26 and 6/30/26 current staff were re-educated by the Healthcare Director or designee on 2600.23a and again on 7/14/26 on elopement prevention and response procedures, resident supervision requirements as outlined in each resident's RASP, monitoring of exit doors and prompt reporting of residents who whereabouts are unknown. Documentation shall be maintained.

On 7/1/26, the Maintenance Director reviewed the functionality of all door security systems, alarms, delayed egress devices, and other safety equipment to ensure they were working properly. LSSI Technologies was at the building on 7/3/26 and verified all doors are working properly. Documentation shall be maintained.

Starting 7/20/3036, (DIRECTED: The audits shall begin on 7/22/26. [redacted]7/22/26). the Healthcare Director or designee will conduct weekly audits for 4 weeks, followed by monthly audits for the next two months, to verify that:
**Staff are following resident supervision requirements*
**Resident RASPS accurately reflect supervision needs*
**Elopement prevention interventions are consistently implemented*

23a - Activities of Daily Living Assistance (continued)

Any identified concerns will be addressed immediately through coaching, additional education, or corrective action as appropriate. Documentation shall be maintained.

On 7/28/2026, the Residence Director or designee, will review the above findings for 2600.23.a during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Proposed Overall Completion Date: 07/28/2026

Directed Completion Date: *07/28/2026*

Update: *07/22/2026*

Please edit the date in the monitoring step. That POC step includes the year of "3036"

Evidence of Completion ***Implemented [redacted] 07/30/2026)***

See attached.

42s - Privacy

2. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

According to the home's "Communication and Electronic Devices" policy, "Cameras (including use of cell phone cameras), audio and/or video equipment are prohibited from being used at any time on Legend property unless used for business-related reasons and pre-approved by Home Office." On or around 6/15/26, direct care staff persons A and B used their personal cell phones to take a photograph of a bruise on resident #5's right arm; however, both photographs of resident #5 depicted the resident in a state of undress.

Plan of Correction ***Accept [redacted] - 07/22/2026)***

The facility acknowledges the findings and is committed to protecting each resident's privacy, dignity, and confidentiality.

Immediately upon discovery of the incident, both staff members A & B were instructed to permanently delete the photographs from their personal cellular phones in the presence of the Healthcare Director. The incident was investigated by the Healthcare Director, and appropriate corrective action was taken with staff member A and B. The resident's representative was notified on 6/30/26 of the incident in accordance with facility policy.

On 7/14/2026, the Residence Director or designee educated current staff on resident rights, privacy, dignity, confidentiality, and the facility's policies regarding the use of personal electronic devices and photography. Training emphasized that personal cell phones are prohibited from being used to photograph residents. Documentation shall be maintained.

Starting 7/20/2026, the Residence Director or designee will meet with 10 staff weekly for 4 weeks and ask them to reiterate what they know about the residents right to privacy. Additional training will be given at that time if needed. Documentation shall be maintained.

42s - Privacy (continued)

On 7/28/2026, the Residence Director or designee, will review the above findings for 2600.42.s during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *07/28/2026*

Evidence of Completion ***Implemented [redacted] 07/30/2026)***

See attached.

103d - Storing Food Off Floor

3. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

At 11:11am, there were 16 cases of bottled water stored on the floor in the 1st floor storage office.

Plan of Correction ***Accept [redacted] 07/22/2026)***

The facility acknowledges the findings and is committed to maintaining proper food and beverage storage practices in accordance with regulatory requirements.

On 7/1/2026, upon identification of the concern, the Dining Director moved all cases of bottled water that were stored directly on the floor and relocated to approved shelving/pallets, ensuring they were stored off the floor and protected from contamination.

On 7/2/2026, the Dining Director was re-educated on proper storage requirements by the Residence Director, including the requirement that all food and beverage items be stored off the floor on approved shelving or pallets. Training also included proper inspection of storage areas to ensure continued compliance. Documentation shall be maintained.

Starting 7/20/2026, the Dining Director or designee will conduct weekly inspections of all food and beverage storage areas for a period of three months to verify that all products are being stored appropriately. Any deficiencies identified during these inspections will be corrected immediately and reviewed with the staff responsible. Documentation shall be maintained.

On 7/28/2026, the Residence Director or designee, will review the above findings for 2600.103.d during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *07/28/2026*

Evidence of Completion ***Implemented [redacted] 07/30/2026)***

See attached.

225c - Additional Assessment

4. 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 #6's most recent assessment, dated [redacted]/26, indicates resident #6 has no problem with irritability and agitation; however, according to numerous staff person interviews, resident #6 has recently been experiencing increased irritability and agitation following resident #6's admission to the home's SDCU on [redacted]/26.

Plan of Correction ***Accept [redacted] 07/22/2026)***

On 7/1/2026, Resident #6's assessment was reviewed by the Healthcare Director and revised to accurately reflect the resident's increased irritability and agitation following admission to the secure dementia care unit. The resident's care plan was also reviewed and updated, as appropriate, to address the identified behaviors and interventions necessary to meet the resident's current needs.

On July 20, 2026, the Healthcare Director, and Assistant Healthcare Director who are responsible for completing resident assessments will be re-educated by the Residence Director on the requirements for completing accurate and timely assessments, including the obligation to update assessments following significant changes in a resident's physical, cognitive, or behavioral status. Training will emphasize the importance of incorporating observations from direct care staff and interdisciplinary team members to ensure assessments accurately reflect the resident's current functioning. Documentation shall be maintained.

By 7/28/26, the Health Care Director or designee will conduct an audit of current SDCU resident assessments to verify that behavioral information accurately reflects each resident's current status and that corresponding care plans are current. Any discrepancies identified will be corrected at that time. Documentation shall be kept.

Starting 7/20/2026, the Healthcare Director or designee will review 5 resident assessments weekly for 4 weeks and then bi weekly for 4 weeks to verify that assessments are updated following significant changes in condition and accurately reflect residents' current needs. Documentation shall be maintained.

On 7/28/2026, the Residence Director or designee, will review the above findings for 2600.225.c during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *07/28/2026*

Evidence of Completion ***Implemented [redacted] - 07/30/2026)***

See attached.

254c - Records Storing

5. Requirements

2600.
254.c. Resident records shall be stored in locked containers or a secured, enclosed area used solely for record storage and be accessible at all times to the administrator or the administrator's designee, and upon request, to the Department or representatives of the area agency on aging.

254c - Records Storing *(continued)*

Description of Violation

At 11:14am, the upper-right cabinet at the 1st floor medication station was unlocked, unattended and accessible, which contained numerous Hospice binders that included diagnoses and medication lists for numerous residents to include residents #1, #2 and #3.

Plan of Correction ***Accept [redacted] - 07/22/2026)***

Immediately upon identification of the deficiency, the cabinet containing protected health information was secured and locked. Staff were reminded that cabinets and storage areas containing confidential resident records must remain locked whenever they are unattended or not in active use to prevent unauthorized access.

On 7/14/2026, current employees with access to protected health information received re-education on confidentiality requirements, HIPAA, and the facility's policies regarding the safeguarding of resident records. Training emphasized the proper storage of PHI, the requirement to secure cabinets and file storage areas when unattended, and each employee's responsibility to protect resident confidentiality at all times. This training was conducted by the Residence Director. Documentation shall be maintained.

Starting 7/20/2026, the Residence Director or designee will conduct random weekly audits for 4 weeks and then Bi weekly for 4 weeks of all areas where protected health information is stored. This will include locked cabinets, file drawers, and other secure storage locations remain locked when unattended. Any deficiencies identified during these audits will be corrected immediately. Documentation shall be maintained.

On 7/28/2026, the Residence Director or designee, will review the above findings for 2600.254.c during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *07/28/2026*

Evidence of Completion ***Implemented ([redacted] - 07/30/2026)***

See attached.