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

August 27, 2026

[redacted], EXECUTIVE DIRECTOR
MCCANDLESS SQUARE SENIOR LIVING LLC
551 COOPER ST
WEXFORD, PA, 15090

RE: ASHTON COMMONS SENIOR LIVING
551 COOPER STREET
WEXFORD, PA, 15090
LICENSE/COC#: 45354

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/27/2026, 07/28/2026 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: *ASHTON COMMONS SENIOR LIVING* **License #**: *45354* **License Expiration**: *08/14/2027*

Address: *551 COOPER STREET, WEXFORD, PA 15090*

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

Administrator

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

Legal Entity

Name: *MCCANDLESS SQUARE SENIOR LIVING LLC*

Address: *551 COOPER ST, WEXFORD, PA, 15090*

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

Certificate(s) of Occupancy

Type: *I 2* **Date**: *01/19/2022* **Issued By**: *Town of McCandless*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *128* **Waking Staff**: *96*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *07/28/2026*

Inspection Dates and Department Representative

07/27/2026 On Site: [redacted]

07/28/2026 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *140* **Residents Served**: *102*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *1st FL* **Capacity**: *16* **Residents Served**: *16*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *102*

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

Have Mobility Need: *26* **Have Physical Disability**: *0*

Inspections / Reviews

07/27/2026 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *08/20/2026*

Inspections / Reviews *(continued)*

08/13/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/25/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/31/2026*

08/27/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/25/2026*

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

103g - Storing Food

1. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 7/27/26 at 11:10am, there was an open and unsealed bag containing approximately 30 frozen hamburger patties in the Kolpak walk-in freezer, located in the home's kitchen.

Plan of Correction ***Accept ([redacted] - 08/13/2026)***

-On 7/27/2026, the frozen hamburger patties were immediately discarded.
-Beginning 7/27/2026, Culinary Director and all staff were educated on proper food storage requirements. Documentation of education will be kept on file.
-Beginning 7/27/2026, Culinary Director or representative will conduct inspection of refrigerators and freezers to ensure all food products are properly sealed, labeled and dated. Inspection will continue 5 days/week.
-Compliance will be monitored by Culinary Director and ED to ensure continued adherence and reviewed at the monthly Quality Management Meeting.
-Documentation of Quality Management Meeting review will be kept on file.

Licensee's Proposed Overall Completion Date: *08/31/2026*

Implemented ([redacted] - 08/27/2026)

187d - Follow Prescriber's Orders

2. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #1 is currently prescribed Diclofenac Sodium 1% gel-Apply 2 grams topically 4 times daily to the right knee; however, from 7/1/26 through 7/27/26, this medication was only administered to resident #1 3 times daily at 8:00am, 2:00pm and 8:00pm.

Repeated Violation-10/6/2025

Plan of Correction ***Accept ([redacted] - 08/13/2026)***

-on 7/28/2026, WD verified with physician that the directions in the MAR were correct. Medication instructions on the label were updated.
-Beginning 7/28/2026, WD, Nurses and Med Techs were educated on the requirements of 2600.187.d and the importance of thorough and accurate documentation while administering medication, including matching the directions on the label with the MAR. Documentation of education will be kept on file.
-Beginning 7/28/2026 Wellness Director or representative will audit 20 random MAR and written medication records to ensure accuracy (5 for each med cart). Audit will continue 1x/week for 3 months. Audits will then continue 1x/month to ensure ongoing compliance. Audit will be kept on file.
-Review of audit will be conducted at the quality management meeting monthly. Documentation of quality management review will be kept on file.

Licensee's Proposed Overall Completion Date: *08/31/2026*

187d - Follow Prescriber's Orders *(continued)*

Implemented ([redacted] - 08/27/2026)

190a - Completion Medication Course

3. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Direct care staff person A has not successfully completed the annual practicums in accordance with the Department-approved medication administration course since March 2025; however, direct care staff person A has administered medications to numerous residents on numerous dates/times, to include the following medication administrations to resident #1 on 7/6/26, 7/10/26 and 7/14/26:

- *At approximately 8:00am and 2:00pm on those dates, direct care staff person A administered 2 grams of Diclofenac Sodium-1% gel to resident #1*
- *At approximately 9:00am on those dates. direct care staff person A administered 1 tablet of Escitalopram-10mg tablet to resident #1*

Plan of Correction ***Accept ([redacted] - 08/13/2026)***

-On 7/27/2026, Staff Person A was removed from medication administration duties and will not resume medication administration until all required Department-approved medication administration training and competency/practicum requirements have been successfully completed and documented.
-Beginning 7/27/2026, The Wellness Director reviewed Direct Care Staff Person A's medication administration records for the dates identified in the citation to determine whether any medication errors or adverse resident outcomes occurred. No Errors or adverse resident outcomes occurred.
-Beginning 7/27/2026, Wellness Director and Executive Director completed an audit of the medication administration training records of all non-licensed staff currently responsible for medication administration. No other staff members were found to have an expired, incomplete, or otherwise noncompliant medication administration training requirement.
-Beginning 7/27/2026, Wellness Director, Executive Director, Scheduler and Nurses were educated on the requirements of Department-approved medication administration course training and annual practicums. Documentation of education will be kept on file.
-Beginning 7/27/2026 and continuing 1x/month. Wellness Director or representative will audit all Med Tech records to ensure compliance with annual practicums, training and education. Results of audit will be reviewed at monthly Quality Management meeting. Documentation of Quality Management meeting will be kept on file.

Licensee's Proposed Overall Completion Date: *08/31/2026*

Implemented ([redacted] - 08/27/2026)

225c - Additional Assessment

4. Requirements

2600.

225c - Additional Assessment *(continued)*

225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #2's most recent assessment was completed on [redacted] however, resident #2's previous assessment was completed on [redacted]

Repeated Violation-4/3/2025

Plan of Correction ***Accept ([redacted] - 08/13/2026)***

-Upon identification of the deficiency, the resident's annual assessment was reviewed and updated to ensure that the resident's current needs, abilities, and required services were accurately identified. The resident's support plan was also reviewed to ensure that it accurately reflects the resident's current assessment and care needs.
-On 7/28/2026, Wellness, Executive Director and Nurse were educated on the importance of the requirements of 2600.225.c. Education will be kept on file.
-Beginning on 7/28/26, Wellness Director or designee completed an audit of all current resident records to verify that annual assessments were completed within the required timeframe. Any assessment identified as overdue or outside of the required timeframe was completed immediately, and the corresponding support plan was reviewed and revised as necessary.
-Beginning on 7/28/2026, A centralized audit has been implemented that identifies each resident's most recent assessment date and next annual assessment due date. The Wellness Director or designee will review the tracking system monthly and identify assessments coming due within the next 30 days to allow sufficient time for completion.
-Results of the centralized audit will be kept and reviewed at the monthly Quality Management meeting. Quality Management notes will be kept on file.

Licensee's Proposed Overall Completion Date: *08/31/2026*

Implemented ([redacted] - 08/27/2026)

227h - Support Plan Refuse Sign

5. Requirements

2600.
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 #4's support plan, dated [redacted], is not signed by resident #4 and does not indicate if resident #4 was unable to participate, declined to participate, refused to sign or was unable to sign.

Plan of Correction ***Accept ([redacted] - 08/13/2026)***

-Upon identification of the deficiency, the resident's annual assessment was reviewed with the resident and updated to ensure that the resident's current needs, abilities and required services were accurately identified. The resident then signed the support plan.
-On 7/28/2026, Wellness Director, Executive Director and Nurses were educated on the importance of the requirements of 2600.227.h. Documentation of education will be kept on file.
-Beginning on 7/28/2026, Wellness Director or designee completed an audit of all current resident records to verify

227h - Support Plan Refuse Sign (continued)

that annual assessments were completed and signed appropriately notated of inability or refusal to sign.
-Beginning on 7/28/2026, a centralized audit has been implemented that identifies each resident's most recent assessment date and next annual assessment due date. The Wellness Director or designee will review all newly completed assessment support plans to verify they have been fully completed.
-Results of the centralized audit will be kept and reviewed at the monthly quality management meeting. Qualify Management notes will be kept on file.

Licensee's Proposed Overall Completion Date: *08/31/2026*

Implemented ([redacted] - 08/27/2026)