

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

September 14, 2026

[REDACTED], ADMINISTRATOR
WELLTOWER OPCO GROUP LLC
[REDACTED]
ATTN LICENSING
[REDACTED]

RE: HEMSLEY HOUSE PERSONAL &
MEMORY CARE OF UPPER ST CLAIR
500 VILLAGE DRIVE
UPPER ST CLAIR, PA, 5241
LICENSE/COC#: 44882

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/10/2026, 08/11/2026 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: HEMSLEY HOUSE PERSONAL & MEMORY CARE OF UPPER ST CLAIR **License #:** 44882 **License Expiration:** 12/15/2026
Address: 500 VILLAGE DRIVE, UPPER ST CLAIR, PA 5241
County: ALLEGHENY **Region:** WESTERN

Administrator

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

Legal Entity

Name: WELLTOWER OPCO GROUP LLC
Address: [REDACTED], ATTN LICENSING, [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: I-2 **Date:** 10/25/2005 **Issued By:** Township of Upper St. Clair

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 84 **Waking Staff:** 63

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal **Exit Conference Date:** 08/11/2026

Inspection Dates and Department Representative

08/10/2026 - On-Site: [REDACTED]
08/11/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 94 **Residents Served:** 55

Secured Dementia Care Unit

In Home: Yes **Area:** Reflections 3rd floor **Capacity:** 36 **Residents Served:** 22

Hospice

Current Residents: 15

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 55
Diagnosed with Mental Illness: 1 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 29 **Have Physical Disability:** 1

Inspections / Reviews

08/10/2026 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 08/28/2026

Inspections / Reviews (*continued*)

08/31/2026 POC Submission

Submitted By: [REDACTED] Date Submitted: 09/11/2026

Reviewer: [REDACTED] Follow Up Type: Document Submission Follow Up Date: 09/19/2026

09/14/2026 Document Submission

Submitted By: [REDACTED] Date Submitted: 09/11/2026

Reviewer: [REDACTED] Follow Up Type: Not Required

95 - Furniture and Equipment

1. Requirements

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 8/10/26 at 11:09 a.m., the perforated grid strainer in the sink of the common bathroom near room #313 was broken and there was just one large opening to the drain.

Plan of Correction

Accept () - 08/31/2026)

In response to the violation on 08/10/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 08/10/2026 by the Maintenance Director to remove the perforated grid strainer upon discovery.

On 8/11/2026, the Maintenance Director audited common place sinks/strainers to ensure all others were in good repair. No additional concerns found. Documentation shall be maintained.

On 8/26/2026, the Residence will train current staff on the requirements housed in 2600.95. Documentation shall be maintained.

Starting 8/18/2026, the Maintenance Director or Designee will 9 sink audits weekly for 4 weeks and then 9 sinks monthly for 2 months. Documentation shall be maintained.

On 9/2/2026, the Residence Director or designee will review the above findings for 2600.95 during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: 09/18/2026

Implemented () - 09/14/2026)

101j7 - Lighting/Operable Lamp

2. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 8/10/26 at approximately 10:50 a.m., there was no operable lamp or other source of lighting that could be turned on at bedside in room #326.

Plan of Correction

Accept () - 08/31/2026)

On 8/10/2026, the Maintenance Director placed a tap light by the residence bed side to gain immediate compliance to 2600.101j.

On 08/11/2026, the Maintenance Director audited all bedside lights to ensure they were in good repair. No other concerns were noted. Documentation will be maintained.

101j7 Lighting/Operable Lamp (continued)

On 08/26/2026, the Residence Director held a current staff meeting to review Regulation 2600.101j. Documentation will be maintained.

Starting 08/18/2026, the Maintenance Director will perform weekly audits of 9 resident bed side lights throughout the community for 4 weeks, then will audit 9 resident bed side lights monthly for 2 months to ensure compliance with 2600.101j. Documentation will be maintained.

On 9/2/2026, the Residence Director or designee will review the above findings for 2600.101j during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained. for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: 09/18/2026

Implemented (█ - 09/14/2026)

103f - Refrigerator/Freezer Temps**3. Requirements**

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 8/10/26 at 11:25 a.m., there was an opened 24 oz jar of Pace Chunky Salsa in the pantry to the left of the sink in the Activities kitchen. The label indicates "refrigerate immediately after opening."

Repeated Violation 7/14/25 et al.

Plan of Correction

Accept (█ - 08/31/2026)

On 8/10/2026 the Life Enrichment Coordinator removed and threw away the Salsa from the kitchen.

On 08/26/2026, the Residence Director held a current staff meeting to review Regulation 2600.103g. Documentation will be maintained.

On/ 8/27/2026, the Dining Director or designee will audit all kitchen cabinets to ensure items are appropriately stored, and any items found to not meet regulatory guidelines will be discarded and replaced accordingly. Documentation will be maintained.

Starting 8/31/2026, the Dining Director or designee will conduct weekly audits of dry storage areas to ensure regulatory compliance with 2600.103g for 4 weeks, then monthly for 2 months. Any areas of non compliance will be addressed immediately, and education will be provided. Documentation will be maintained.

On 9/2/2026, the Residence Director or designee will review the above findings for 2600.103g during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained for further review and continuous improvement.

103f Refrigerator/Freezer Temps (*continued*)

Licensee's Proposed Overall Completion Date: 09/18/2026

Implemented () - 09/14/2026

125a - Combustible Storage

4. Requirements

2600.

125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On 8/10/26 at 11:53 a.m., there were numerous items behind the residential sized dryer in the laundry room including torn up tissues, a blue towel, an ivory colored towel, a tan cloth napkin, 2 small plastic cups and a 5 gallon bucket of wallpaper adhesive.

Plan of Correction

Accept () - 08/31/2026

On 8/10/2026, the Maintenance Director removed all materials and debris behind the first floor dryer immediately to obtain compliance to 2600.125a.

On 08/11/2026, the Maintenance Director audited all dryers in the community, and no other areas of concern were noted. Documentation will be maintained.

On 08/26/2026, the Residence Director held a current staff meeting to review Regulation 2600.125a in full. Documentation will be maintained.

Starting 08/31/2026, the Maintenance Director or designee will perform audits daily for 2 weeks and then weekly for 2 weeks to ensure cleanliness and lack of debris in dryer areas. Documentation will be maintained.

On 9/2/2026, the Residence Director or designee will review the above findings for 2600.125a during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained. for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: 09/18/2026

Implemented () - 09/14/2026

131c - Kitchen Fire Extinguisher

5. Requirements

2600.

131.c. A fire extinguisher with a minimum 2A-10BC rating shall be located in each kitchen. The kitchen extinguisher must meet the requirements for one floor as required in subsection (a).

Description of Violation

On 8/10/26 at 11:25 a.m., there was no fire extinguisher in the kitchen area of the second floor activities room.

Plan of Correction

Accept () - 08/31/2026

On 8/10/2026, the Maintenance Director placed a fire extinguisher in the Life Enrichment kitchen area immediately to obtain compliance to 2600.131c

131c - Kitchen Fire Extinguisher (continued)

On 08/11/2026, the Maintenance Director audited all kitchens for appropriate fire extinguishers, and no other areas of concern were noted. Documentation will be maintained.

On 08/26/2026, the Residence Director held a current staff meeting to review Regulation 2600.131c in full. Documentation will be maintained.

Starting 08/18/2026, the Maintenance Director will perform weekly audits of all kitchen fire extinguisher throughout the community for 4 weeks. Documentation will be maintained.

On 9/2/2026, the Residence Director or designee will review the above findings for 2600.131c during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained. for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: 09/18/2026

Implemented () - 09/14/2026)

187a - Medication Record**6. Requirements**

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

6. Dose.

Description of Violation

Resident #1 is ordered Insulin lispro 100units/ml pen – inject unit sub-Q before meals per sliding scale: 0-150 = 0 units; 151-200 = 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units; 401-600 = 12 units. However, on 8/11/26 at 10:40 a.m., the entry for this medication on the resident's August 2026 medication administration record did not have a space to document the amount of units of insulin administered.

Resident #2 is ordered Humalog injection solution 100 unit/ml (insulin Lispro) inject as per sliding scale: if 0-70=0; 71-89=8; 90-119=10; 120-150=12 bolus dose; 151-200=14; 201-250=16; 251-300=18; 301-350=20; 351-400=22; 401-450=24; 451+=26 subcutaneously before meals for diabetes. However, on 8/11/26 at 11:30 a.m., the entry for this medication on the resident's August 2026 medication administration record did not have a space to document the amount of units of insulin administered.

Repeated Violation 7/14/25 et al.

Plan of Correction

Accept () - 08/31/2026)

On 8/10/2026, the Health Care Director contacted the EMAR vendor and ensured that a space for insulin units administered, and site administered were added to all appropriate EMARS.

Starting 8/31/2026, the Health Care Director will review all diabetic EMARs to ensure that units administered and site administered were added appropriately and then will audit for 2600.187a compliance weekly for 4 weeks then bi weekly for 4 weeks. Documentation shall be maintained.

On 08/26/2026, the Residence Director held a current staff meeting to review Regulation 2600.131c in full.

187a - Medication Record (continued)

Documentation will be maintained.

On 9/2/2026 the Residence Director or designee will review the above findings for 2600.187a during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: 09/18/2026

Implemented () - 09/14/2026)

225a - Assessment 15 Days**7. 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 #3's medical evaluation dated [REDACTED] indicates medical diagnoses of anemia, BPH [benign prostatic hyperplasia] and HTN [hypertension]. However, the initial assessment completed [REDACTED] for resident #3, admitted [REDACTED] did not include these diagnoses.

Plan of Correction

Accept () - 08/31/2026)

On 8/10/2026 The Health Care Director reviewed and updated resident #3 assessment and ensured missing diagnosis were appropriately added to the RASP.

By 9/18/2026, the Health Care Director or designee will audit current RASP'S for compliance with 2600.225a. Any RASP found to be out of compliance will have corrections / updates made at that time. Documentation will be maintained.

Starting 8/24/2026, the Residence Director will review any newly completed RASPS to ensure that the requirements of 2600.225a are met weekly for 4 weeks. Documentation shall be maintained.

On 08/26/2026, the Residence Director held a current staff meeting to review Regulation 2600.225a in full. Documentation will be maintained.

On 9/2/2026, the Residence Director or designee will review the above findings for 2600.225a during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained. for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: 09/28/2026

Implemented () - 09/14/2026)

225c - Additional Assessment

8. 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 #4's medical evaluation completed [REDACTED] indicated diagnoses of CHF [congestive heart failure], HTN [hypertension] and GERD [gastroesophageal reflux disease]. However, the annual assessment completed [REDACTED] for resident #4, admitted [REDACTED] did not include these diagnoses.

Plan of Correction

Accept ([REDACTED] - 08/31/2026)

On 8/10/2026 The Health Care Director reviewed and updated resident #4 assessment and ensured missing diagnosis were appropriately added to the RASP.

By 9/18/2026, the Health Care Director or designee will audit current RASP'S for compliance with 2600.225c. Any RASP found to be out of compliance will have corrections / updates made at that time. Documentation will be maintained.

Starting 8/24/2026, the Residence Director will review any newly completed RASPS to ensure that the requirements of 2600.225c are met weekly for 4 weeks.

On 08/26/2026, the Residence Director held a current staff meeting to review Regulation 2600.225c in full. Documentation will be maintained.

On 9/2/2026, the Residence Director or designee will review the above findings for 2600.225c during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained. for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: 09/18/2026

Implemented ([REDACTED] - 09/14/2026)

231c - Preadmission Screening

9. Requirements

2600.

231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #5 was admitted to the home's secure dementia care unit on [REDACTED] However, the resident's written cognitive preadmission screening was completed on [REDACTED]

Plan of Correction

Accept ([REDACTED] - 08/31/2026)

On 8/11/2026, The Residence Director audited Memory Care Pre-Screening tools for date compliance. Documentation will be maintained.

On 08/26/2026, the Residence Director held a current staff meeting to review Regulation 2600.231c in full.

231c Preadmission Screening (continued)

Documentation will be maintained.

Starting on 8/31/2026, the Residence Director or designee will review all new Memory Care Prescreen tools on a weekly basis for 4 weeks, then monthly for 2 months to ensure compliance with 2600.231c. Documentation will be maintained.

On 9/2/2026 the Residence Director or designee will review the above findings for 2600.231c during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: 09/18/2026

Implemented () - 09/14/2026)

234a - Admission Support Plan**10. Requirements**

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #5 was admitted to the home's secure dementia care unit on [REDACTED] However, the resident's initial support plan was completed on [REDACTED]

Plan of Correction

Accept () - 08/31/2026)

On 8/11/2026, the Health Care Director audited RASPs for our Memory Care residents to ensure compliance with 2600.234a. Documentation will be maintained.

On 08/26/2026, the Residence Director held a current staff meeting to review Regulation 2600.234c in full. Documentation will be maintained.

Starting 8/31/2026, the Residence Director or designee will review all new Memory Care RASPs on a weekly basis for 4 weeks, then monthly for 2 months to ensure compliance with 2600.234c. Documentation will be maintained.

On 10/1//2026 the Residence Director or designee will review the above findings for 2600.234c during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: 09/18/2026

Implemented () - 09/14/2026)