

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

September 22, 2026

[REDACTED], CEO
HALCYON SENIOR LIVING LLC
528 DEWEY AVENUE
BRIDGEVILLE, PA, 15017

RE: HALCYON SENIOR LIVING
528 DEWEY AVENUE
BRIDGEVILLE, PA, 15017
LICENSE/COC#: 45109

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/18/2026, 08/19/2026 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: HALCYON SENIOR LIVING

License #: 45109

License Expiration: 08/20/2027

Address: 528 DEWEY AVENUE, BRIDGEVILLE, PA 15017

County: ALLEGHENY

Region: WESTERN

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: HALCYON SENIOR LIVING LLC

Address: 528 DEWEY AVENUE, BRIDGEVILLE, PA, 15017

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-2

Date: 08/03/2020

Issued By: Borough of Bridgeville

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 98

Waking Staff: 74

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal

Exit Conference Date: 08/19/2026

Inspection Dates and Department Representative

08/18/2026 - On-Site: [REDACTED]

08/19/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 88

Residents Served: 67

Secured Dementia Care Unit

In Home: Yes

Area: 2nd floor

Capacity: 44

Residents Served: 30

Hospice

Current Residents: 7

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 67

Diagnosed with Mental Illness: 2

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 31

Have Physical Disability: 1

Inspections / Reviews

08/18/2026 Full

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 09/18/2026

09/18/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/22/2026

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 09/22/2026

Inspections / Reviews (*continued*)

09/22/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/22/2026

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

91 - Telephone Numbers**1. Requirements**

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 8/18/26 at approximately 11:00 a.m., there were no emergency phone numbers posted near the landline telephone located near the second-floor nurse's office.

Plan of Correction**Accept () - 09/18/2026**

Immediately on 9/8/26, administrator placed the emergency phone numbers next to the land line on the 2nd floor.

On 9/8/26, Administrator audited all phone line/emergency number listings to ensure that emergency numbers are listed by each landline phone through out the facility.

On 9/8/26 Administrator reviewed LIS error of 2600.91 and on 9/16/26 administrator educated staff on violation and corrective action and educated on importance of keeping emergency numbers next to phone lines.

Starting week of 9/14/26 Maintenance director or administrator will audit 1x/week for 6 weeks then 1x/month for 2 months, will review placement of emergency number posting near phones

Licensee's Proposed Overall Completion Date: 09/16/2026

Implemented () - 09/22/2026**103g - Storing Food****2. Requirements**

2600.

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

Description of Violation

On 8/18/26 at approximately 3:30 p.m., there was an opened, unsealed 12 lb box of pork sausage links with approximately half of the sausages remaining in the reach-in double-door stainless steel freezer in the home's kitchen. The sausages were layered in the box between sheets of wax paper. The top layer of sausages was uncovered.

Plan of Correction**Accept () - 09/18/2026**

Immediately on 8/19/26, culinary director placed proper seal between the sausage layers.

On 9/8/26, Administrator and culinary director audited walk-in freezer, walk-in refrigerator, reach-in refrigerator, reach-in freezer. Completed any corrective actions.

On 9/16/26 Administrator reviewed and educated all staff on violation and proper storage of items.

Starting week of 9/8/26, Culinary director or administrator will audit walk-in freezer, walk-in refrigerator, reach-in freezer, and reach-in refrigerator 3x/week for 4 weeks, then 2x/week for 4 weeks

Licensee's Proposed Overall Completion Date: 09/16/2026

Implemented () - 09/22/2026

130h - Inoperable Smoke Detector

3. Requirements

2600.

130.h. The home's emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

Description of Violation

The home's Fire Watch policy indicates that "Fire watch procedures will be implemented should our fire alarm system be out of working order for more than four (4) hours, or should our sprinkler system be out of working order for more than ten (10) hours."

Plan of Correction

Accept () - 09/18/2026)

Immediately on 9/8/26, administrator changed the policy to state "Immediately" on fire watch policy.

On 9/8/26 Administrator audited other EOP binders to ensure fire watch policy states immediately.

On 9/16/26. Educated staff on LIS violation to the fire watch policy and change to policy.

Starting 9/8/26 administrator change policies within all EOP binders on Fire Watch and policy to be audited/monitor emergency procedures if smoke detector becomes inoperable for 6 months

Licensee's Proposed Overall Completion Date: 09/16/2026

Implemented () - 09/22/2026)

187a - Medication Record

4. Requirements

2600.

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

4. Strength.

Description of Violation

Resident #1 is ordered a compounded nebulizer solution of Formoterol 12 mcg/Budesonide 0.5mg/Glycopyrolate 37.5 mcg, 3.5ml vial, Inhale contents of 1 vial via nebulizer 2 times a day approximately 12 hours apart. However, on 8/19/26 at 12:40 p.m., the entry for this medication on resident #1's August 2026 medication administration record indicates Breztri Aerosphere Inhalation Aerosol 160-9-4.8 MCG/ACT (Budesonide-Glycopyrrolate-Formoterol Fumarate) 3.5ml inhale orally two times a day.

Plan of Correction

Accept () - 09/18/2026)

As correct medication and correct prescription was present within the facility, Director of Nursing immediately contacted the pharmacy on 8/19/26, who had profiled the medication incorrectly, to amend the prescription dosage to match the medication and the prescription.

Initiated cart audit on 9/16/26; completed by DON and business office manager, correcting any documentation errors from pharmacy. Also house pharmacy is being changed to new pharmacy on 8/26/26.

On 9/16/26, Educated all staff on LIS violation and educated staff to carefully, monitor each card prior to administration.

187a - Medication Record (continued)

Starting 9/28/26 Director of Nursing and will complete a cart audit every two weeks for 6 weeks then 1/x month for 2 months.

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

Implemented () - 09/22/2026)

225c - Additional Assessment

5. Requirements

2600.

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

1. Annually.

Description of Violation

Resident #1's medical evaluation completed () indicates a diagnosis of repeated falls. However, the resident's assessment completed () does not address this diagnosis/need.

Plan of Correction

Accept () - 09/18/2026)

On 9/8/16 DON Immediately added the dx to the RASP in as an addendum.

On 9/16/26, Administrator started audit of all RASP/DMEs for all residents completed to be completed by 9/18/26

On 9/16/26 Administrator educated staff on importance of proper accuracy with documentation in accordance to 225c.

Starting on 9/16/26 Administrator and/or Director of Nursing will audit all new residents and annual, yearly, or significant change documents for 4 months

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

Implemented () - 09/22/2026)

226a - Mobility Assessment

6. Requirements

2600.

226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

Resident #2's medical evaluation completed () indicates the resident's mobility as moderate (Immobile). However, the resident's initial assessment completed () indicates the resident's mobility assessment as Independent (Mobile).

Plan of Correction

Accept () - 09/18/2026)

Immediately, on 8/20/26, administer changed the mobility status from mobile to immobile in the RASP.

On 9/16/26, administrator audited all residents and their mobility status and their DM to ensure accuracy

on 9/16/26, Administrator educated staff on violation and how improper documentation can impact clinical care

226a - Mobility Assessment (continued)

Administrator or DON will audit medical evaluations and RASPs for accuracy for all new residents and newly completed documents for 4 months

Licensee's Proposed Overall Completion Date: 09/16/2026

Implemented ( **- 09/22/2026)**