



CENTER FOR MEDICARE

February 23, 2026

WARNING LETTER

Contract ID: H5902

Parent Organization Name: Senior LIFE Altoona, Inc.

Legal Entity: SENIOR LIFE ALTOONA, INC.

Roxanne Miloro
Medicare Compliance Officer
429 Manor Drive
Ebensburg, PA 15931

VIA EMAIL: SLEDirectors@seniorlifeebensburg.com

Subject: Failure to Ensure Participant Safety, Service Coordination, and Quality Oversight

Dear Roxanne Miloro:

The Centers for Medicare & Medicaid Services (CMS) is issuing this warning letter to Senior LIFE Altoona, Inc, which operates the Programs of All-Inclusive Care for the Elderly (PACE) Contract ID H5902, regarding your organization's failure to ensure participant safety, service coordination, and quality oversight as required by CMS.

Your organization is non-compliant with the following:

- 42 C.F.R. § 460.63, which requires PACE organizations to adopt and implement effective compliance oversight requirements, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements. This includes having procedures to voluntarily self-report potential fraud or misconduct related to the PACE program to CMS.
- 42 C.F.R. § 460.76(a), which requires PACE organizations to ensure transportation services are safe, accessible, and equipped to meet the needs of the participant population.
- 42 C.F.R. § 460.98(a), which requires PACE organizations to provide care that meets the needs of each participant across all care settings, 24 hours a day, every day of the year, and must establish and implement a written plan to ensure that care is appropriately furnished.
- 42 C.F.R. § 460.106(d)(1), which requires the interdisciplinary team to continuously implement, coordinate, and monitor the plan of care regardless of whether services are furnished by the PACE employees or contractors, across all care settings.

- 42 C.F.R. § 460.112(a)(2), which states that each participant has the right to be treated with dignity and respect.
- 42 C.F.R. § 460.112(a)(5), which states that each participant has the right to be free from harm, including neglect.
- 42 C.F.R. § 460.130, which requires PACE organizations to maintain an effective quality program and take actions that result in improvements in its performance in all types of care.

Your organization is out of compliance with these PACE requirements because your organization failed to implement the necessary operational safeguards to ensure participant safety during a participant's offsite medical appointment, including failing to confirm escort coverage to the appointment, neglecting to ensure the participant wore a safety device as described in the plan of care, and failing to monitor the completion of transportation services.

In April 2025, the Pennsylvania State Administering Agency (SAA) was notified by Adult Protective Services of substantiated caregiver neglect. The SAA informed CMS that one of your organization's participants, who had documented cognitive impairment and multiple comorbidities, was left unattended outside a medical facility for more than eight hours. In those eight hours, the participant was exposed to cold and rainy conditions and did not have access to food, water, or medications. The participant was eventually found by law enforcement officers and reunited with the caregiver.

The SAA promptly conducted an unannounced onsite investigation. The SAA found that this failure placed the participant at serious risk of harm and revealed your organization's operational deficiencies across multiple areas, including transportation oversight, safety monitoring, and quality assurance processes. A joint review meeting with your organization, the SAA, and CMS was held shortly after. At that meeting, your organization disclosed that this failure occurred due to issues with transportation scheduling, communication between staff, and emergency response protocols.

As a part of that meeting, CMS requested that your organization conduct a root cause analysis of the incident to determine what operational failures occurred. CMS also requested that your organization review participant safety protocols and implement corrective measures to prevent this failure in the future. The root cause analysis found that the home care coordinator failed to confirm that an escort request had been received by the contracted provider; the transportation coordinator failed to appropriately monitor transportation schedules, resulting in late transport and missed assignments; staff failed to ensure the participant wore their life alert device that tracks their location to the appointment; and staff failed to communicate with the Interdisciplinary Team (IDT) that the participant's appointment was rescheduled that same day and still required an escort.

Your organization reported that the home care and transportation coordinators received disciplinary action, and several staff members received re-education on the communication requirements around transportation needs. In addition, all transportation scheduling staff received re-education on how to denote which appointments require a transportation escort. Your organization also reported updates to several policies and practices, including, but not limited to, requiring daily confirmation of transportation escort assignments with the IDT, adjusting transportation schedules to allow for additional time when necessary, and requiring the transportation coordinator to verify all trips are scheduled prior to the end of each shift.

Please be aware that this letter will be included in the record of your organization's past performance, which CMS will consider as part of the review of any application for new or expanded PACE program agreements your organization may submit. CMS notes that this compliance notice is being issued based exclusively on information obtained from sources other than your organization's self-disclosure.

If you have any questions about this notice, please contact your CMS Account Manager Crystal Rollins Gautier at: (215) 861-4265, or Crystal.RollinsGautier@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink, appearing to read 'JC' or similar, with a stylized flourish.

Jeremy C. Willard, Director
Division of Surveillance, Compliance & Marketing
Medicare Drug & Health Plan Contract Administration Group
Centers for Medicare and Medicaid Services

CC via email:

Crystal Rollins Gautier, Kathy Covert, CMS
Christine Reinhard, CMS Baltimore