pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **UMH PA CORP**
LEGAL ENTITY

To operate **WESLEY VILLAGE**
NAME OF FACILITY OR AGENCY

Located at **215 ROBERTS ROAD, PITTSTON, PA 18640**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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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 **157**
(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 20**

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 **October 16,** **2026** until **August 15,** **2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **241880**

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: October 16, 2026

[redacted]
UMH PA CORP
[redacted]

RE: Wesley Village
215 Roberts Road
Pittston, Pennsylvania 18640
License #: 241880

Dear [redacted]:

As the result of your home's recent request to adjust the use of the physical space, the Department has granted an approval for a revised license issued under the authority of 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). The approved capacity revision request is an increase in SDCU capacity to 20. Total license capacity of the facility remains unchanged at 157. The expiration date of the license remains unchanged.

Any future requests for changes in capacity should be forwarded to the Department for review and consideration in accordance with the applicable regulations. The revised license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
License

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

October 5, 2026

[redacted]
UMH PA CORP
[redacted]

RE: WESLEY VILLAGE
215 ROBERTS ROAD
PITTSTON, PA, 18640
LICENSE/COC#: 24188

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/20/2026, 09/08/2026 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: *WESLEY VILLAGE* **License #:** *24188* **License Expiration:** *08/15/2027*

Address: *215 ROBERTS ROAD, PITTSTON, PA 18640*

County: *LUZERNE* **Region:** *NORTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *UMH PA CORP*

Address: [redacted]

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *11/02/2000* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *73* **Waking Staff:** *55*

Inspection Information

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

Reason: *Renewal, Interim* **Exit Conference Date:** *09/08/2026*

Inspection Dates and Department Representative

08/20/2026 - On-Site: [redacted]

09/08/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *157* **Residents Served:** *65*

Secured Dementia Care Unit

In Home: *No* **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *65*

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

Have Mobility Need: *8* **Have Physical Disability:** *0*

Inspections / Reviews

08/20/2026 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/02/2026*

09/25/2026 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/01/2026*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/30/2026*

Inspections / Reviews *(continued)*

10/01/2026 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/01/2026*

Reviewer: [redacted] **Follow-Up Type:** *Bypass Document Submission*

10/01/2026 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *10/01/2026*

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

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On 8/20/26 at 9:45 a.m. agents of the Department requested a list of current residents and access to the resident records. Access to the home's electronic resident records was not provided until 11:55 p.m.

Plan of Correction ***Accept [redacted] - 09/25/2026)***

Corrective Action Taken: On August 20, 2026, Department representatives requested access to the current resident list and resident records. The facility experienced a technical difficulty with the login to the electronic resident record system, which delayed access to the requested records. The issue was addressed, and access to the electronic records was subsequently provided.

The administrator reviewed the incident with the appropriate staff and reinforced that Department representatives must be provided immediate access to the home, residents, and records upon request. Staff were also reminded that if an electronic access issue occurs, the concern must be immediately reported to the administrator or designee so that an alternate method of providing the requested records can be implemented without unnecessary delay. Prevention of Recurrence: The facility has reviewed its process for responding to Department requests for records and will maintain an alternate means of accessing or providing current resident information and records in the event of an electronic system or login issue. Staff responsible for resident records have been instructed on this process. Monitoring: The administrator or designee will periodically verify that designated staff have working access to the electronic resident record system and understand the procedure for providing records if a technical issue occurs. Any identified concern will be addressed promptly through troubleshooting, staff education, or other corrective action as needed.

Date of Compliance:
8/21/2026

Licensee's Proposed Overall Completion Date: *09/22/2026*

Implemented [redacted] - 10/01/2026)

65b - Rights/Abuse 40 Hours

2. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
2. Emergency medical plan.
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff persons A and B did not have training in Emergency Medical Plan and Reporting of reportable incidents and conditions within 40 scheduled working hours.

65b - Rights/Abuse 40 Hours *(continued)*

Plan of Correction ***Accept [redacted] - 09/25/2026)***

Plan of Correction – 2600.65(b) Staff Orientation

Corrective Action Taken: Staff persons A and B were provided with training on the emergency medical plan and reporting of reportable incidents and conditions. The administrator reviewed the required orientation topics with the staff and ensured the training was documented.
Prevention: The administrator or designee will ensure all newly hired direct care staff, ancillary staff, substitute personnel, and volunteers receive the required orientation topics within 40 scheduled working hours. Orientation requirements and completion dates will be tracked.
Monitoring: During monthly staff training record audits, the administrator or designee will review orientation records to verify required training on the emergency medical plan and reporting of reportable incidents and conditions has been completed within 40 scheduled working hours. Any missing or overdue training will be addressed promptly.

Date of Compliance: _____8/24/2026_____

65b- What date did staff person A & B were retrained. The trainings were launched on 8/20/26 to 9/23/2026 window of completion. Both A & B completed the trainings on 9/18 & 9/22.
What date for the audits: The Administrator went through the staff list & audit on 9/2/26 to make sure all were up to date and current.

Licensee's Proposed Overall Completion Date: *09/25/2026*

Implemented [redacted] - 10/01/2026)

65f - Training Topics

3. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

Description of Violation

Staff persons C and D did not receive training in Medication self-administration or instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during the 2025 training year.

Plan of Correction ***Accept [redacted] - 09/25/2026)***

Plan of Correction – 2600.65(f) Annual Training Topics
Corrective Action Taken:
Staff persons C and D were provided with training on medication self-administration and instruction on meeting the needs of residents as identified in the preadmission screening form, assessment tool, medical evaluation, and support plan. Completion of the training was documented in their training records.

Prevention:

65f - Training Topics (continued)

The administrator or designee will ensure all direct care staff receive the required annual training topics. Annual training requirements will be reviewed and tracked to ensure required topics are completed during each training year.

Monitoring:
During monthly staff training record audits, the administrator or designee will review direct care staff training records to verify required annual training topics have been completed. Any missing or overdue training will be addressed promptly.

Date of Compliance: _____8/24/2026_____

65f-What date did staff person C & D were retrained. The trainings were launched on 8/20/2026 to be complete by 9/23/2026. Staff member C completed trainings 8/21/2026,9/7/2026 & 9/14/26. Staff Member D completed the trainings on 9/10/2026 & 9/22/2026.
What date for the audits. The Administrator went through all staff list & audit on 9/3/2026.

Licensee's Proposed Overall Completion Date: *09/25/2026*

Implemented [redacted] - 10/01/2026)

85a - Sanitary Conditions

4. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 8/18/26 resident #1's blood sugar was tested using resident #2's glucometer.
At 2:30 p.m. there was dried blood observed on the pharmacy label attached to resident #3's Toujeo insulin pen.

Plan of Correction ***Accept [redacted] - 09/25/2026)***

Plan of Correction – 2600.85(a) Sanitary Conditions
Corrective Action Taken:
Staff were immediately re-educated regarding the proper use of resident-specific blood glucose monitoring equipment. Resident #1's blood sugar was tested using Resident #2's glucometer, and staff were reminded that glucometers are resident-specific and may not be shared. The Toujeo insulin pen for Resident #3 was also reviewed and cleaned/replaced as appropriate due to blood observed on the pharmacy label.
Prevention: Medication and direct care staff were reminded to maintain sanitary conditions and to use resident-specific equipment and supplies. Staff were instructed to verify the resident and equipment before each blood glucose test and to report any contamination or sanitary concern immediately.

Monitoring: During monthly medication cart audits and routine resident care observations, the administrator or designee will verify that resident-specific glucometers and supplies are being used and that medication supplies are maintained in sanitary condition. Any concerns identified will be corrected promptly.

85a - Sanitary Conditions (continued)

Date of Compliance: _____8/20/2026_____

85a-Date of re-education? 8/20/2026-8/21/206
Date Toujeo insulin pen was cleaned? 8/20/2026
Date of cart audits. Weekly audits began by administrator 8/27

Licensee's Proposed Overall Completion Date: *09/25/2026*

Implemented [redacted] - 10/01/2026)

91 - Telephone Numbers

5. 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

At 1:45p.m., there were no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in resident room 114.

Plan of Correction ***Accept [redacted] - 09/25/2026)***

2600.91 – Emergency Telephone Numbers
Corrective Action Taken:
The emergency telephone numbers were posted on or by the telephone in resident room 114, including the required contact information for emergency services. The administrator or designee also reviewed all telephones with an outside line throughout the home to ensure the required emergency telephone numbers were posted and readily available.
Prevention of Recurrence:
Staff education occurred 9/9/2026 that emergency telephone numbers must remain posted on or by each telephone with an outside line. Staff were instructed to report any missing, damaged, or outdated emergency telephone information to the administrator or designee so it can be replaced promptly.
Monitoring:
The administrator or designee will conduct a monthly inspection of telephones with outside lines to verify that the required emergency telephone numbers are posted, legible, and readily accessible. Any identified deficiency will be corrected at the time it is identified.

Date of Compliance:
9/8/2026

91- What date were the emergency phone numbers posted? 9/8/2026

Licensee's Proposed Overall Completion Date: *09/25/2026*

Implemented [redacted] - 10/01/2026)

101j7 - Lighting/Operable Lamp

6. Requirements

101j7 - Lighting/Operable Lamp *(continued)*

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

Resident rooms #10 and #13 in the secure dementia unit did not have access to a source of light that can be turned on/off at bedside. Light switches installed on the walls in these bedrooms were not within arm's reach of the bed.

Plan of Correction ***Accept [redacted] - 09/25/2026)***

2600.101(j)(7) – Operable Lamp or Other Source of Lighting
Corrective Action Taken: The lighting concern identified in resident rooms 10 and 13 was addressed. Each affected bedroom was provided with an operable source of lighting that can be turned on and off from the bedside and is within the resident's reach.
The administrator or designee also reviewed the bedrooms throughout the home to ensure residents have access to an operable bedside light or other source of lighting that can be operated from the bedside.
Prevention of Recurrence: Staff were reminded that each resident bedroom must have an operable source of lighting that can be turned on and off at bedside. Staff were instructed to report any lighting concern, including a lamp that is not functioning or a light source that is not within the resident's reach, to the administrator or designee.
Monitoring: The administrator or designee will include bedside lighting in the monthly resident room safety inspection. Any identified concern will be corrected promptly.
Date of Compliance:
9/9/2026
What date were the lamps installed? Beds were moved closer to the light switch for the light. 9/8/17

What date did the administrator/designee review bedrooms? All 17 rooms furniture were adjusted following the survey on 9/20/2026. All light switches are within reachable distance for residents to turn on the lamp mounted on the wall.

Licensee's Proposed Overall Completion Date: *09/25/2026*

Implemented [redacted] - 10/01/2026)

103f - Refrigerator/Freezer Temps

7. 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

At 10:15 a.m. there was no thermometer in the 1st floor kitchenette freezer.
At 10:30 a.m. there was no thermometer in the 2nd floor kitchenette freezer.

Plan of Correction ***Accept ([redacted] - 09/25/2026)***

2600.103(f) – Refrigerator/Freezer Temperatures

Corrective Action Taken:
Thermometers were placed in the first floor kitchenette freezer and the second floor kitchenette freezer. The

103f - Refrigerator/Freezer Temps (continued)

administrator or designee also checked the refrigerators and freezers throughout the home to verify that thermometers are present and functioning.
Prevention of Recurrence: Staff responsible for the kitchenettes were reminded that refrigerators and freezers must have thermometers available to monitor food storage temperatures. Staff were instructed to report any missing or damaged thermometer to the administrator or designee so it can be replaced promptly.

Monitoring:
The administrator or designee will verify during routine kitchen checks that thermometers are present in all refrigerators and freezers and are functioning properly. Any concern identified will be corrected promptly.

Date of Compliance:
8/21/2026

What date were the thermometers replaced? 8/20/26 Immediately following Survey

How often will the monitoring take place? monthly Audit of all refrigerators and freezers in Anderson Personal Care. 1st audit is attached.

Licensee's Proposed Overall Completion Date: *09/25/2026*

Implemented [redacted] - 10/01/2026)

103i - Outdated Food

8. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

At 2:45 p.m. there was a dented 6 pound can of shredded sauerkraut in the dry food storage area.

Plan of Correction ***Accept [redacted] - 09/25/2026)***

2600.103(i) – Outdated or Damaged Food

Corrective Action Taken:
The dented can of sauerkraut identified during the survey was removed from the dry food storage area and discarded. The administrator or designee reviewed the dry food storage areas to ensure food items were in acceptable condition and that no outdated, spoiled, or damaged cans were being stored for use.
Prevention of Recurrence:
Staff were reminded that outdated or spoiled food and dented cans may not be used. Staff were instructed to report and remove any questionable food item from storage.
Monitoring:
The administrator or designee will include food condition in routine kitchen and storage area checks. Any outdated, spoiled, or damaged food identified will be removed promptly.

Date of Compliance:
8/21/2026

103i - Outdated Food (continued)

What date is the dented can discarded? 8/20/2026, During the Survey.

How often will checks take place? Monthly Audits (1st audit attached) Date? 8/21/2026

Licensee's Proposed Overall Completion Date: *09/25/2026*

Implemented [redacted] - 10/01/2026)

124 - Notice to Fire Department

9. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

On 9/8/26 the home did not have documentation of written notification to the local fire department regarding the addition of the Secure Dementia Unit, including the capacity of the unit, the location of the bedrooms, and the assistance required to evacuate in an emergency.

Plan of Correction ***Accept [redacted] - 09/25/2026)***

2600.124 – Notice to Fire Department
Corrective Action Taken:
The local fire department was provided written notification regarding the Secure Dementia Unit, including the unit capacity, bedroom locations, and the assistance residents may require during an emergency evacuation. A copy of the written notification and documentation of delivery will be maintained at the home.

Prevention of Recurrence:
The administrator or designee was reminded that the local fire department must be notified in writing when changes to the home affect the information required for emergency evacuation. Documentation of all notifications will be maintained at the home.
Monitoring:
The administrator or designee will review the fire department notification information annually and whenever there is a change to the home, bedroom locations, resident capacity, or evacuation needs to ensure the information remains current.
Date of Compliance:
9/9/2026

What date was the notice to the fire department completed? 9/8/2026. hand delivered on 9/9/2026

Licensee's Proposed Overall Completion Date: *09/25/2026*

Implemented [redacted] - 10/01/2026)

125a - Combustible Storage

10. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

125a - Combustible Storage *(continued)*

Description of Violation

At 10:27 a.m. there was a pillowcase found behind the dryer on top of the dryer vent in the 1st floor laundry room. Repeated violation 8/26/25.

Plan of Correction ***Accept [redacted] - 09/25/2026)***

Plan of Correction – 2600.125(a) Combustible Storage
Corrective Action Taken:
The pillowcase found behind the dryer and on top of the dryer vent in the 1st floor laundry room was immediately removed. The laundry room was inspected to ensure combustible or flammable materials were not located near the dryer or other heat sources.
Prevention: Staff were reminded that combustible and flammable materials must be kept away from dryers, hot water heaters, and other heat sources. Staff will report and remove items found in unsafe locations.
Monitoring: The administrator or designee will include laundry rooms and areas around heat sources in routine monthly safety inspections. Any concerns identified will be corrected promptly.

Date of Compliance: 8/21/2026

What date was the pillowcase removed? 8/20/2026 immediately following the survey.

What date were staff informed of combustible and flammable materials? 8/20/2026 and 8/21/206 for the staff that were not on site during the survey.

Licensee's Proposed Overall Completion Date: *09/25/2026*

Implemented [redacted] - 10/01/2026)

132c - Fire Drill Records

11. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The home conducted a fire drill on 12/6/25 at 4:15 a.m. with four staff participating in the fire drill. The home's fire drill logs indicate that five staff persons participated in the fire drill conducted on 12/6/25.

Plan of Correction ***Accept [redacted] - 09/25/2026)***

Plan of Correction – 2600.132(c) Fire Drill Records
Corrective Action Taken:
The fire drill record for 12/6/25 was reviewed due to the discrepancy in the number of staff documented as participating. Staff were reminded that fire drill documentation must accurately reflect the number of staff who participated.
Prevention:
Staff responsible for conducting and documenting fire drills were re-educated on completing all required

132c - Fire Drill Records (continued)

information accurately and verifying the record before it is finalized.
Monitoring:
The administrator or designee will review fire drill records after each drill to ensure required information is complete and accurate. Any discrepancies will be corrected promptly.

Date of Compliance: 8/21/2026

What date was the review? reviewing the drill record on 8/20/2026 after the survey the fire drill record was found in the binder. unfortunately the surveyors closed and had left.
What date was the re-education? 8/21/2026 Administration and the observers

Licensee's Proposed Overall Completion Date: *09/25/2026*

Implemented [redacted] - 10/01/2026)

184a - Resident's Meds Labeled

12. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #4 is prescribed Metoprolol Tartrate 50mg, one tablet two times a day, hold if systolic blood pressure is less than 100 or heart rate is less than 60.
The pharmacy label does not include the instructions to hold the medication for the above listed parameters.

Plan of Correction ***Accept [redacted] - 09/25/2026)***

Plan of Correction – 2600.184(a)(4) Resident Medication Labeling
Corrective Action Taken: The medication label for Resident #4's Metoprolol Tartrate 50 mg was reviewed due to the pharmacy label not including the complete administration instructions. The pharmacy was contacted and the medication labeling was addressed to include the prescribed hold parameters.
Prevention: Medication staff were reminded that prescription medications must have pharmacy labels that include the prescribed dosage and complete instructions for administration, including any hold parameters.
Monitoring: During routine med cart audits, the administrator or designee will review resident medications and pharmacy labels to ensure the dosage and administration instructions are complete and match the current medication orders. Any discrepancies identified will be reported and corrected promptly.
Date of Compliance: ___8/24/2026_____

What date is the corrective action? Immediately following the survey. 8/20/2026

Was training conducted? Yes Date? 8/20/2026 & 8/21/2026 for remaining staff

What date was the audit of the cart? Audit started 9/3/2026 (see attached audit)

Licensee's Proposed Overall Completion Date: *09/25/2026*

184a - Resident's Meds Labeled *(continued)*

Implemented [redacted] - 10/01/2026)

190a - Completion Medication Course

13. 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

On 8/20/26, staff person C's most current completed annual practicum for medication administration was dated [redacted]/25.

Plan of Correction ***Accept [redacted] 09/25/2026)***

Plan of Correction – 2600.190(a) Medication Administration Course
Corrective Action Taken: Staff person C's medication administration training record was reviewed after it was identified that the most recent completed annual practicum was dated 7/19/25. The staff member was scheduled for and completed the required medication administration practicum to ensure current competency before administering medications on 8/20/2026.
Prevention: Medication administration staff were reminded that required medication administration training and competency must remain current. The administrator or designee will track expiration and renewal dates to ensure staff complete required training within the required timeframe.
Monitoring
During monthly medication and staff training record audits, the administrator or designee will review medication administration training and practicum dates to ensure they remain current. Any upcoming or expired training will be addressed promptly.
Date of Compliance: _____8/20/2026_____

Licensee's Proposed Overall Completion Date: *09/23/2026*

Implemented [redacted] - 10/01/2026)