

Department of Human Services  
Bureau of Human Service Licensing

February 6, 2022

[REDACTED]

WOLF RUN VILLAGE LLC  
3750 ROUTE 220 HIGHWAY  
HUGHESVILLE, PA, 17737

RE: WOLF RUN VILLAGE  
3750 ROUTE 220 HIGHWAY  
HUGHESVILLE, PA, 17737  
LICENSE/COC#: 22149

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/13/2021, 08/16/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,  
Michele Moskalczyk

Enclosure  
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

**Facility Information**

Name: *WOLF RUN VILLAGE* License #: *22149* License Expiration: *03/21/2022*  
Address: *3750 ROUTE 220 HIGHWAY, HUGHESVILLE, PA 17737*  
County: *LYCOMING* Region: *NORTHEAST*

**Administrator**

Name: [REDACTED] Phone: *5705840101* Email: [REDACTED]

**Legal Entity**

Name: *WOLF RUN VILLAGE LLC*  
Address: *3750 ROUTE 220 HIGHWAY, HUGHESVILLE, PA, 17737*  
Phone: *5705840101* Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *I-1* Date: *11/12/2009* Issued By: *Code Inspectors*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *52* Waking Staff: *39*

**Inspection Information**

Type: *Partial* Notice: *Unannounced* BHA Docket #:  
Reason: *Incident* Exit Conference Date: *08/13/2021*

**Inspection Dates and Department Representative**

*08/13/2021 - On-Site:* [REDACTED]

*08/16/2021 - Off-Site:* [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *75* Residents Served: *51*

**Secured Dementia Care Unit**

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

**Hospice**

Current Residents: *2*

**Number of Residents Who:**

Receive Supplemental Security Income: *2* Are 60 Years of Age or Older: *51*  
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *2*  
Have Mobility Need: *1* Have Physical Disability: *0*

Inspections / Reviews

08/13/2021 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *11/20/2021*

01/06/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*

Follow-Up Date: *01/10/2022*

02/06/2022 - Document Submission

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

## 16c - Written Incident Report

## 1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

**Description of Violation**

On 06/24/21 resident #1 suffered a fall at approximately 5:15am. Prior to the fall resident #1 ambulated independently and transferred without assistance. Staff notes and staff interviews indicate that after the fall the resident was unable to walk and also required the assistance of 2 to 3 staff persons for care due to the resident's level of pain. A mobile x-ray confirmed that the resident had a hip fracture on 6/25/21. The home did not report the incident to the department's regional office until 6/28/21.

**Plan of Correction****Accept**

This was an isolated incident due to the following: The resident had been discharged from the hospital [REDACTED] after a 5 day stay for a COPD flareup. The POA stated that while in the hospital the resident was in a 4-point restrained because [REDACTED] was so scared and confused with being in a strange place without having familiar faces around [REDACTED]. Visitation was restricted at the hospital due to Covid protocols. While in the hospital the decision was made to bring [REDACTED] back to Wolf Run Village on hospice. The resident was admitted to hospice on [REDACTED] with a terminal diagnosis of dementia. The POA had been making all decisions for the resident for the past few years. The resident had a fall around 5:15am on 6/24. The staff did an assessment and assisted [REDACTED] up. After [REDACTED] was up, he could not walk to [REDACTED] chair. The staff assisted [REDACTED] to [REDACTED] chair and called the POA. The POA refused EMS. The staff contacted the Administrator. The administrator contacted the POA. Who again Refused EMS. The Administrator could not obtain consent from the POA to have EMS take [REDACTED] to the ER but did get [REDACTED] to agree to follow the directions of the Hospice care plan. Hospice Assessed the resident and stated that [REDACTED] was not showing signs of pain at that time..

On 6/25 the administrator called Hospice to attempt again to have the resident further evaluated as the resident was showing signs of pain when staff was trying to perform care for [REDACTED]. Again, the POA would not agree to EMS but did agree to a mobile x-ray. POA was fighting for resident to stay at Wolf Run as it was familiar, the family could be with [REDACTED] and even if it was a fracture, [REDACTED] was not a candidate for surgery. The x-ray was completed on 6/25 around 11pm. The results were sent to Wolf Run to be forwarded to the PCP. The staff was in contact with hospice and the new orders were given for increased comfort medications.

On 6/27/2021 the Administrator spoke to the hospice nurse about the fact that the Resident had a femoral head fracture, and [REDACTED] pain was not under control. The decision was made to arrange a transfer to the hospice inpatient unit for pain management. The hospice nurse contacted the family and arranged for transport on 6/28/21 at 10AM.

Unfortunately the incident report to the department was forgotten while trying to do what was best for the resident and his POA/family. The report was sent on Monday morning as soon as the Administrator realized the staff had not sent it over on 6/26.

Staff was educated on the policy for timely reporting. If the incident needs to be reported and they are unsure of how/what to do they are to call the administrator no matter what time of day or night. If the Administrator can not be reached, they are to contact the Resident Care Coordinator or the Assistant Administrator.

The administrator will monitor all chart notes and incident reports daily for timely reporting going forward.

## 16c - Written Incident Report (continued)

Document Submission

Implemented

## 142a - Secure Medical Care

## 1. Requirements

2600.

142.a. The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

## Description of Violation

On 6/24/21 resident #1 suffered a fall in the bedroom at approximately 5:15am. According to staff interviews, the resident could not walk after the fall and required the assistance of multiple staff members when providing toileting and changing due to the resident's level of pain. The resident's family member was notified of the fall and of the resident's condition but declined to agree to have the resident sent to the hospital. A mobile x-ray confirmed that the resident had a hip fracture on 6/25/21. According to staff interviews, staff had difficulty providing care from 6/24/21 to [REDACTED] when [REDACTED] was transferred to an inpatient hospice facility. The home failed to secure immediate medical attention for the resident following the fall by failing to send the resident to the hospital for evaluation after the fall, despite the resident showing obvious signs of injury.

## Plan of Correction

Accept

This was an isolated incident due to the following: The resident had been discharged from the hospital on [REDACTED] after a 5 day stay for a COPD flareup. The POA stated that while in the hospital the resident was in a 4-point restrained because [REDACTED] was so scared and confused with being in a strange place without having familiar faces around [REDACTED]. Visitation was restricted at the hospital due to Covid protocols. While in the hospital the decision was made to bring [REDACTED] back to Wolf Run Village on hospice. The resident was admitted to hospice on [REDACTED] 1 with a terminal diagnosis of dementia. The POA had been making all decisions for the resident for the past few years. The resident had a fall around 5:15am on 6/24. The staff did an assessment and assisted [REDACTED] up. After [REDACTED] was up, [REDACTED] could not walk to [REDACTED] chair. The staff assisted him to [REDACTED] and called the POA. The POA refused EMS. The staff contacted the Administrator. The administrator contacted the POA. Who again Refused EMS. The Administrator could not obtain consent from the POA to have EMS take him to the ER but did get her to agree to follow the directions of the Hospice care plan. Hospice Assessed the resident and stated that [REDACTED] was not showing signs of pain at that time..

On 6/25 the administrator called Hospice to attempt again to have the resident further evaluated as the resident was showing signs of pain when staff was trying to perform care for him. Again, the POA would not agree to EMS but did agree to a mobile x-ray. POA was fighting for resident to stay at Wolf Run as it was familiar, the family could be with [REDACTED] and even if it was a fracture, [REDACTED] was not a candidate for surgery. The x-ray was completed on 6/25 around 11pm. The results were sent to Wolf Run to be forwarded to the PCP. The staff was in contact with hospice and the new orders were given for increased comfort medications.

On 6/27/2021 the Administrator spoke to the hospice nurse about the fact that the Resident had a femoral head fracture, and [REDACTED] pain was not under control. The decision was made to arrange a transfer to the hospice inpatient unit for pain management. The hospice nurse contacted the family and arranged for transport on [REDACTED] at 10AM.

The facility followed the Hospice Care Plan while still attempting to have the resident treated at a hospital.

The policy has been reviewed and covered with the staff on what to do if someone requires immediate medical

**142a - Secure Medical Care (continued)**

attention. Wolf Run Village will send a resident to the hospital for any situation requiring emergency medical attention that is not related to the terminal diagnosis. For non-emergencies and items related to the terminal diagnosis, the staff will contact the hospice group first.

Administrator will monitor for compliance.

**Document Submission**

**Implemented**