

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

May 6, 2025

[REDACTED], BOARD PRESIDENT
SUGAR VALLEY LODGE INC
190 SUGAR VALLEY LANE
FRANKLIN, PA, 16323

RE: SUGAR VALLEY LODGE (HICKORY
ACRES BUILDING)
190 SUGAR VALLEY LANE
FRANKLIN, PA, 16323
LICENSE/COC#: 44770

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/20/2025 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: SUGAR VALLEY LODGE (HICKORY ACRES BUILDING) License #: 44770 License Expiration: 01/05/2025
 Address: 190 SUGAR VALLEY LANE, FRANKLIN, PA 16323
 County: VENANGO Region: WESTERN

Administrator

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

Legal Entity

Name: SUGAR VALLEY LODGE INC
 Address: 190 SUGAR VALLEY LANE, FRANKLIN, PA, 16323
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-1 Date: 05/20/2016 Issued By: Sugar Creek Borough

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 25 Waking Staff: 19

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal Exit Conference Date: 02/20/2025

Inspection Dates and Department Representative

02/20/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 28 Residents Served: 25

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 23 Are 60 Years of Age or Older: 23
 Diagnosed with Mental Illness: 25 Diagnosed with Intellectual Disability: 1
 Have Mobility Need: 0 Have Physical Disability: 0

Inspections / Reviews

02/20/2025 - Full

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/23/2025

04/03/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: 04/29/2025
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 04/07/2025

Inspections / Reviews *(continued)*

04/10/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/29/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 04/30/2025

05/06/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/29/2025

Reviewer: [REDACTED]

Follow-Up Type: Not Required

3c - Post Current License

1. Requirements

2600.

- 3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

At 10:46 AM the home failed to have the most recently completed licensing inspection summary posted 4/30/24.

Plan of Correction

Accept ([REDACTED] - 04/01/2025)

On 2/20/2025 [REDACTED] acknowledged the most recent licensing inspection summary was not hanging in the folder.

On 2/20/2025 [REDACTED] placed the most recent licensing summary in the folder on the wall.

Starting on 3/20/2025 [REDACTED] will audit monthly the licensing summary folders hanging to ensure all the licensing Summaries are posted.

Licensee's Proposed Overall Completion Date: 03/20/2025

Implemented ([REDACTED] - 05/06/2025)

25b - Contract Signatures

2. Requirements

2600.

- 25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The administrator or designee did not sign resident #1's resident-home contract, dated [REDACTED]

The resident and the administrator or designee did not sign resident #2's resident-home contract, dated [REDACTED]

Plan of Correction

Accept ([REDACTED] - 04/01/2025)

On 2/20/2025 [REDACTED] acknowledged [REDACTED] did not sign the residents R/B contract for 2025.

On 2/25/2025 [REDACTED] went through all resident contracts and made sure the Administrator signature was signed.

Starting on 3/20/2025 [REDACTED] will conduct chart audits monthly making sure signature is on all documents required.

Licensee's Proposed Overall Completion Date: 03/20/2025

Implemented ([REDACTED] - 05/06/2025)

82a - Poisonous Materials

3. Requirements

2600.

- 82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

At 11:09 AM the housekeeping room across from the medication room had a 4/5 full, clear plastic spray bottle containing a tan liquid that did not have a manufacturer's label.

82a - Poisonous Materials (continued)

Plan of Correction

Accept (████ - 04/08/2025)

On 2/20/2025 █████ acknowledged there was a chemical in a bottle without a label on it.

On 2/20/2025 █████ discarded the unlabeled bottle and its contents and talked with housekeeping about only using bottles with labels.

Starting on 4/20/2025 █████ will check weekly to ensure no chemicals are being placed in unlabeled bottles. Staff will be provided education on the risk of toxic chemicals as well as proper labeling.

Licensee's Proposed Overall Completion Date: 04/04/2025

Implemented (████ - 05/06/2025)

85a - Sanitary Conditions

4. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

At 11:00 a.m., the common bathroom next to resident room 308 did not have any paper towels or means of drying hands. The electrical drying unit's electrical cord was cut.

Plan of Correction

Accept (████ - 04/09/2025)

On 2/20/2025 █████ acknowledged the hand dryer had its cord cut. █████ then ordered a new hand dryer.

On 2/25/2025 █████ contacted county Maintenance to install the new hand dryer.

Starting on 3/20/2025 █████ Administrator will check all bathrooms monthly as well as add this to check to the quality management plan.

Hand Dryer was replaced on 3/30/2025. In the interim paper towels were present in the bathrooms.

Licensee's Proposed Overall Completion Date: 04/04/2025

Implemented (████ - 05/06/2025)

85e - Trash Outside Home

5. Requirements

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At approximately 11:30 AM the Left side door of the right dumpster was open exposing an open area of approximately three by three foot. The dumpster was approximately one half full of refuse.

At approximately 11:30 AM the left side door of the left dumpster was open exposing an open area of approximately three by three foot in size. Multiple garbage bags were overflowing through the opening.

85e - Trash Outside Home (continued)

Plan of Correction

Accept () - 04/02/2025

On 2/20/2025 acknowledged that doors were open due to overflowing trash.

On 2/20/2025 Called Waste Management and made sure our pickup time was that night.

On 3/20/2025 will check the dumpsters weekly to ensure lid is closed. If the issue would persist and trash overflow more frequently an extra pickup time will be arranged.

Licensee's Proposed Overall Completion Date: 03/20/2025

Implemented () - 05/06/2025

86b - Bathroom

6. Requirements

2600.

86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

At 11:06 the common bathroom directly across from the beauty salon did not have a ventilation fan. This bathroom did not have a window.

At 11:07 the Coleman bathroom directly across from the home's medication office did not have an operable ventilation fan. This bathroom did not have a window.

Plan of Correction

Accept () - 04/09/2025

On 2/20/2025 informed of the issue in those bathrooms. Venango County Human Services, and Venango County Maintenance had these bathrooms shut off due to this.

On 2/20/2025 determined the Hickory Acres has an excess of bathrooms and due to the maintenance cost to put fans in place these bathrooms will be closed permanently

Starting on 4/1/2025 will work with Venango County on changes that need made.

Hickory Acres will have 6 working restrooms with closing of those 2. The ratio is 1 for every 6 people. Hickory Acres has a max capacity of 28 residents. Closing these restrooms will still allow Sugar Valley Lodge to stay within ratio.

Licensee's Proposed Overall Completion Date: 04/04/2025

Implemented () - 05/06/2025

103c - Food Protected

7. Requirements

2600.

103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

At approximately 11:25 AM there was an uncovered glass of chocolate mousse located in the home's kitchen's walk in freezer. Staff indicated it was from the previous night's activities. Additionally, there was an unsealed large plastic bag of Tater tots.

Plan of Correction

Accept () - 04/09/2025

On 2/20/2025 acknowledged an employee put their ice cream in the fridge and the open tater tots.

103c - Food Protected (continued)

On 2/20/2025 [redacted] posted a memo of no staff placing food in walk in.
On 3/20/2025 [redacted] will check walk in monthly to ensure all food is properly stored/labeled.

The exposed food was discarded. Nutrition staff were provided education on proper food storage/handling on 4/4/2025.

Licensee's Proposed Overall Completion Date: 04/04/2025

Implemented ([redacted] - 05/06/2025)

126a - Furnace Inspection

8. Requirements

2600.
126.a. A professional furnace cleaning company or trained maintenance staff person shall inspect furnaces at least annually. Documentation of the inspection shall be kept.

Description of Violation

The homes furnace was most recently inspected on 5/24/23.

Plan of Correction Accept ([redacted] - 04/09/2025)

On 2/20/2025 [redacted] acknowledged [redacted] did not have the most recent furnace inspection.
On 2/24/2025 [redacted] emailed most recent furnace inspection to [redacted].
Starting on 3/14/2025 [redacted] Administrator will monitor that the most recent furnace inspection is in the quality management monthly checks.

The most recent Furnace inspections was completed September 3rd, 2024.

Licensee's Proposed Overall Completion Date: 04/04/2025

Implemented ([redacted] - 05/06/2025)

132b - Safety Inspection/Fire Drill

9. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home's most recent fire safety inspection completed by a fire safety expert was completed on 9/24/24. However, the previously conducted fire safety inspection was completed on 7/17/23.

Plan of Correction Accept ([redacted] - 04/09/2025)

On 2/20/2025 [redacted] explained to [redacted] what had happened causing the Fire Safety Expert to be delayed. Fire Chief stepped down causing a delay.
On 2/20/2025 [redacted] contacted Rocky Grove Fire Department to schedule the next Fire Safety Expert inspection to be on 9/24/2025.
Starting on 3/20/2025 [redacted] Administrator will work with Rocky Grove Fire Department to ensure this does not happen in the future. Policy and Procedure will be implemented citing what will take place in the event of cancelation.

Licensee's Proposed Overall Completion Date: 04/04/2025

132b - Safety Inspection/Fire Drill (*continued*)*Implemented (█ - 05/06/2025)*

132c - Fire Drill Records

10. 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 fire drills conducted on 11/29/24 and 2/8/25 did not indicate if the time of the drill was a.m., or p.m.

Plan of Correction*Accept (█ - 04/09/2025)*

On 2/20/2025 █ acknowledged the am/pm indicator was hard to read but was present.

On 2/20/2025 █ talked with Administrator █ about writing more legible.

Starting on 3/20/2025 █ will go through fire drill log and make sure all am/pm are legible these checks will take place monthly.

Licensee's Proposed Overall Completion Date: 04/04/2025

Implemented (█ - 05/06/2025)

132d - Evacuation

11. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home had a safe evacuation time of 5 minutes designated in writing by a fire safety expert on 9/24/25. However, the following fire drills exceeded that time:

-On 11/29/24, A fire drill was conducted that took 7 minutes and 2 seconds to complete.

-On 12/31/24, A fire drill was conducted that took 9 minutes and 30 seconds to complete.

-On 1/24/25, A fire drill was conducted that took 5 minutes and 30 seconds to complete.

Plan of Correction*Directed (█ - 04/09/2025)*

On 2/20/2025 █ acknowledged there were different 3 different occasions where the safe evacuation time was exceeded.

132d - Evacuation (continued)

On 2/25/2025 [REDACTED] spoke with staff conducting said drills about what took place. It was highlighted that different residents were either in the shower/going to the bathroom at these times. Starting on 3/20/2025 [REDACTED] will continue to track our evacuation times to ensure we safely get out under 5 minutes.

Starting on 4/20/2025 [REDACTED] Administrator will meet with staff members conducting fire drills and see what pitfalls are taking place. During these meetings it will be discussed how to most effectively evacuate in a timely manner. Through these discussions we will track each month our improvements and continue these to ensure the effectiveness remains.

Proposed Overall Completion Date: 04/04/2025

DIRECTED PLAN:

By 4/30/25 - If a monthly fire drill exceeds the maximum safe evacuation time established by the fire safety expert, the administrator shall review staffing hours provided, the evacuation needs of each resident served in the home and the home's fire evacuation policy and procedure to determine the root cause of the noncompliant fire drill evacuation time. The administrator shall conduct additional unannounced fire drills until residents can evacuate within the safe evacuation time.

By 4/30/25 - All staff persons shall be trained on regulation 2600.132d and the home's fire drill policy and plan to evacuate residents within the safe evacuation time. Documentation of the training shall be kept.

By 4/30/25 - The administrator shall observe the next 3 consecutive fire drills and ensure that staffing levels are adequate to meet the evacuation needs of the residents as specified in the residents' assessments and support plans in accordance with 2600.60a.

Directed Completion Date: 04/30/2025

Implemented ([REDACTED]) - 05/06/2025)

185a - Implement Storage Procedures

12. Requirements

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #4 was prescribed blood sugar checks every morning. The resident's glucometer indicated a blood glucose reading of 124 on 2/14/25 at 8:00 AM. However, the residents February medication administration record indicated a blood glucose reading of 128 for that date and time.

Plan of Correction

Accept ([REDACTED]) - 04/09/2025)

On 2/20/2025 [REDACTED] Acknowledged the the glucometer reading did not match the administration record.

On 2/20/2025 [REDACTED] Med Lead talked with the med tech who made the error about properly inputting data. All staff will be trained on this in the med tech meeting.

Starting on 3/20/2025 [REDACTED] Med lead will track glucometers through monthly Med Audits as well as weekly Med tech meetings.

185a - Implement Storage Procedures (*continued*)

Licensee's Proposed Overall Completion Date: 04/04/2025

Implemented ([REDACTED] - 05/06/2025)