

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

June 17, 2025

[REDACTED], BOARD PRESIDENT  
SUGAR VALLEY LODGE INC  
[REDACTED]  
[REDACTED]

RE: SUGAR VALLEY LODGE (POLK)  
196 CHURCH STREET  
POLK, PA, 16342  
LICENSE/COC#: 44549

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/11/2025 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 (POLK) License #: 44549 License Expiration: 04/24/2025  
 Address: 196 CHURCH STREET, POLK, PA 16342  
 County: VENANGO Region: WESTERN

## Administrator

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

## Legal Entity

Name: SUGAR VALLEY LODGE INC  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

## Certificate(s) of Occupancy

Type: R-4 Date: 07/30/2013 Issued By: Venango County

## Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 20 Waking Staff: 15

## Inspection Information

Type: Full Notice: Unannounced BHA Docket #:  
 Reason: Renewal Exit Conference Date: 03/11/2025

## Inspection Dates and Department Representative

03/11/2025 - On-Site: [REDACTED]

## Resident Demographic Data as of Inspection Dates

## General Information

License Capacity: 15 Residents Served: 14

## Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

## Hospice

Current Residents: 0

## Number of Residents Who:

Receive Supplemental Security Income: 11 Are 60 Years of Age or Older: 8  
 Diagnosed with Mental Illness: 7 Diagnosed with Intellectual Disability: 6  
 Have Mobility Need: 6 Have Physical Disability: 0

## Inspections / Reviews

## 03/11/2025 - Full

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 04/11/2025

## 04/29/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: 06/02/2025  
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 05/05/2025

Inspections / Reviews *(continued)*

05/09/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/02/2025

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 06/06/2025

06/17/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/02/2025

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

The home did not have a copy of the Chapter 2600 regulations posted in a conspicuous and public place in the home.

Plan of Correction

Accept ( ) - 04/29/2025)

03/11/2025- COO was told about the Chapter 2600 regulations not being posted.

3/11/2025- COO posted the Chapter 2600 regulations book on the public bulletin board.

3/11/2025- Starting on 4/1/2025- COO will continue to make sure the most updated book is posted on the public board through monthly audits.

Licensee's Proposed Overall Completion Date: 04/02/2025

Implemented ( ) - 06/17/2025)

20b1 - Financial Records

2. Requirements

2600.

20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:

1. The home shall keep a record of financial transactions with the resident, including the dates, amounts of deposits, amounts of withdrawals and the current balance.

Description of Violation

The home manages the finances for resident #1. The resident's record of financial transactions shows a balance of \$156.06 on 3/7/25. It then shows a cash withdrawn of \$25 on 3/11/25 and a new balance of 121.06. However, the new balance should be \$131.06.

Plan of Correction

Accept ( ) - 04/29/2025)

On 3/11/2025- On 3/11/25 COO, during the exit interview was shown that there was an error with resident #1 financial information.

On 3/11/2025, COO called resident #1 back down to the office and had look at the error with COO. Then explained the error and crossed out wrong amount, initialed and dated the error. Then put the correct amount to the right side of the wrong amount.

As of April 2 2025, COO will make any needed corrections in red ink and utilize a calculator to avoid any mathematical errors. Also we will have the financial manager, , check for errors.

Licensee's Proposed Overall Completion Date: 04/02/2025

Implemented ( ) - 06/17/2025)

65a - FS Orientation 1st Day

3. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.

65a - FS Orientation 1st Day (continued)

2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff Member C did not complete any of the orientation training required by this regulation.

Plan of Correction

Accept ( [redacted] ) - 04/29/2025

On 3/11/25 [redacted] COO went through the staff chart and Identified which trainings the employee needed.

On 3/12/25 [redacted] then had the staff person complete the trainings needed in their chart.

By 4/1/2025 [redacted] will audit all employee charts to make sure the trainings needed are in their charts.

[redacted] will add these trainings to onboarding list for new hires to make sure these trainings are getting completed.

Licensee's Proposed Overall Completion Date: 04/11/2025

Implemented ( [redacted] ) - 06/17/2025

65b - Rights/Abuse 40 Hours

4. 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:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff Member C did not complete any of the orientation training required by this regulation.

Plan of Correction

Accept ( [redacted] ) - 04/29/2025

On 3/11/25 [redacted] COO went through the staff chart and Identified which trainings the employee needed.

On 3/12/25 [redacted] then had the staff person complete the trainings needed in their chart.

By 4/1/2025 [redacted] will audit all employee charts to make sure the trainings needed are in their charts.

[redacted] will add these trainings to onboarding list for new hires to make sure these trainings are getting completed.

Licensee's Proposed Overall Completion Date: 04/21/2025

Implemented ( [redacted] ) - 06/17/2025

65f - Training Topics

5. Requirements

65f - Training Topics (continued)

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.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

**Description of Violation**

*Direct care staff member A did not receive training in Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan or infection control and general principals of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration during training year 2024.*

*Direct care staff member B did not receive training in Medication self-administration training or Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 2024.*

*Direct care staff member C did not receive training in Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 2024.*

**Plan of Correction**

**Accept (████ - 05/09/2025)**

*On 3/11/2025, ██████████ COO went through the prior years training documentation and identified which staff did not receive the training.*

*On 4/1/2025, ██████████ COO audited the employee charts and identified who did not have the trainings listed above.*

*By 5/5/2025, ██████████ COO and ██████████, CEO will have audited all employee charts. Twice a year employee charts will be audited to make sure trainings are being completed and documented.*

**Licensee's Proposed Overall Completion Date: 05/05/2025**

**Implemented (████ - 06/17/2025)**

65g - Annual Training Content

**6. Requirements**

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

65g - Annual Training Content (continued)

**Description of Violation**

Staff person B did not receive training in The Older Adult Protective Services Act or accident prevention during training year 2024.

Staff person D did not receive training in Falls and accident prevention during training year 2024.

**Plan of Correction**

Accept ( ) - 05/09/2025)

On 3/11/2025, [REDACTED] COO went through the prior years training documentation and identified which staff did not receive the training.

On 4/1/2025, [REDACTED] COO audited the employee charts and identified who did not have the trainings listed above.

By 5/5/2025, [REDACTED] COO and [REDACTED] CEO will have audited employee all employee charts, twice a year employee charts will be audited to make sure trainings are being completed. We will audit employee charts twice per year to confirm trainings are being completed and documented for all current staff.

Licensee's Proposed Overall Completion Date: 05/05/2025

Implemented ( ) - 06/17/2025)

107c - Food/Water 3 Day Supply

**7. Requirements**

2600.

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

**Description of Violation**

The home did not have a 3-day supply of nonperishable food in the home.

**Plan of Correction**

Directed ( ) - 05/09/2025)

On 3/11/2025, [REDACTED] COO identified that there was not a 3-day supply on hand at the Sugar Valley Lodge facility in Polk

On 3/12/2025, [REDACTED] COO spoke with the Nutrition group that provides the food for Sugar Valley Lodge to create a letter that states that a 3 day supply is available on site at Sugar creek location. When an emergency arises, the nutrition group will transport the supply to the Polk location.

By 4/11/2025, [REDACTED] COO and [REDACTED] CEO worked with the Nutrition Group to provide Sugar Valley Lodge with 3-day supply of emergency food. We will audit the food annually to check for expiration dates.

Proposed Overall Completion Date: 05/05/2025

**DIRECTED PLAN:**

By 5/15/25 and at least quarterly thereafter: The administrator or designee shall audit the home to ensure there is a 3-day supply of nonperishable food and drinking water present in the home for the residents. Documentation of the audits shall be kept.

Directed Completion Date: 05/05/2025

107c - Food/Water 3 Day Supply (*continued*)*Implemented (█ - 06/17/2025)*

## 227d - Support Plan Medical/Dental

**8. Requirements**

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

**Description of Violation**

*Resident #1's support plan, dated █ includes diagnoses of schizophrenia, paranoid and disorganized thoughts, depression, and anxiety; however, the support plan did not address the specific services the home will provide regarding these diagnoses. The support plan only included a general comment of "meds, counseling" for each diagnosis.*

*Resident #2's support plan, dated █, includes diagnoses of depression, anxiety, and age-related cognitive decline; however, the support plan did not address the specific services the home will provide regarding these diagnoses. The support plan only included a general comment of "medication" for each diagnosis.*

**Plan of Correction***Directed (█ - 05/09/2025)*

*On 3/11/2025, █ COO identified the mental health diagnoses for the above residents.*

*On 4/1/2025, █ COO worked with the Medical Assistant who completes these Support Plans, identified the area on the support plan that requires more documentation of the symptoms and what our plan is to help them when these struggles arise.*

*By 6/15/2025 █ COO and Med Assistant will audit charts to identify where it says "medication" and give a more detailed plan of how we will collaborate with outside services as well as a plan to help the resident utilize coping skills in house. We will audit charts annually to keep the information tailored to the needs of the resident.*

*Proposed Overall Completion Date: 06/15/2025*

**DIRECTED PLAN:**

*By 5/15/25 and at least quarterly thereafter: The administrator or designee shall audit resident support plans to ensure they include a detailed description of the services that the home will provide for all personal care services, including medical and psychological diagnoses. Documentation of the audits shall be kept.*

**Directed Completion Date: 06/15/2025**

*Implemented (█ - 06/17/2025)*