





Pennsylvania  
Department of Human Services

Emailing Date: July 24, 2025

[REDACTED]  
[REDACTED]

Wolf Run Village LLC  
3750 Route 220 Highway  
Hughesville, Pennsylvania 17737

RE: Wolf Run Village  
License #: 221490

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on March 25, 2025 and March 28, 2025, and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

A handwritten signature in black ink that reads "Juliet Marsala".

Juliet Marsala  
Deputy Secretary  
Office of Long-term Living

Enclosures  
License  
Licensing Inspection Summary

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

July 22, 2025

[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 03/25/2025, 03/28/2025 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: WOLF RUN VILLAGE License #: 22149 License Expiration: 03/27/2025
Address: 3750 ROUTE 220 HIGHWAY, HUGHESVILLE, PA 17737
County: LYCOMING Region: NORTHEAST

Administrator

Name: [Redacted]

Legal Entity

Name: WOLF RUN VILLAGE LLC
Address: 3750 ROUTE 220 HIGHWAY, HUGHESVILLE, PA, 17737
Phone: [Redacted]

Certificate(s) of Occupancy

Type: I-2 Date: 11/12/2009 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 66 Waking Staff: 50

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
Reason: Renewal, Provisional Exit Conference Date: 03/28/2025

Inspection Dates and Department Representative

03/25/2025 - On-Site: [Redacted]
03/28/2025 - Off-Site: [Redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 75 Residents Served: 59

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 4

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 59
Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 7 Have Physical Disability: 1

Inspections / Reviews

03/25/2025 - Full

Lead Inspector: [Redacted] Follow-Up Type: POC Submission Follow-Up Date: 04/25/2025

05/08/2025 - POC Submission

Submitted By: [Redacted] Date Submitted: 05/14/2025
Reviewer: [Redacted] Follow-Up Type: Document Submission Follow-Up Date: 05/15/2025

Inspections / Reviews *(continued)*

07/21/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 05/14/2025

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 the License Inspection Summary dated 1/7/25 posted conspicuously in the home.*

## Plan of Correction

Accept [REDACTED] - 04/29/2025)

*The License Inspection Summary dated 1/7/25 was immediately (at the time of the inspection) taken from the spare Inspection Binder kept in the office and placed in the binder that is kept at the sign in desk. A duplicate was printed and placed in the spare binder. The administrator has added the checking of the binder for all inspection summaries to the monthly check list and will continue to monitor for compliance.*

**Licensee's Proposed Overall Completion Date:** 04/22/2025

## Evidence of Completion

Implemented ([REDACTED] 07/21/2025)

*See attached.*

**Update:** 07/21/2025

*Verified with documents and during an on-site POC verification completed 7/11/2025.*

## 17 - Record Confidentiality

## 2. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

## Description of Violation

*At 9:05 a.m. the unattended medication cart located in the D hallway was observed to have an unlocked laptop on top of the cart which displayed residents' photos and names which could be selected to view the resident's Medication Administration Records.*

*An empty pill packet containing a resident's name was observed on top of the medication cart.*

## Plan of Correction

Accept [REDACTED] 04/29/2025)

*A new Med Tech was on the cart for [REDACTED] first solo med pass. The cart was immediately cleared of the empty pill packets and the laptop was locked. The more experienced Med Tech was made aware. [REDACTED] then addressed HIPPA compliance with the new med tech and monitored [REDACTED] for the rest of the shift. The top drawer of all carts were cleared to allow the med techs to place empty pill packets and medication bottles in a locked area until the cart is taken back to the Nurse's station to be disposed of properly. Carts and laptops will be checked at minimum three times per day for the next week then daily for the next month by the Administrator or Designee. The Administrator will cover HIPPA compliance at the staff training on 4/24/25. The Administrator will also cover the HIPPA compliance with all future Med Techs during the first cart training shift.*

**Licensee's Proposed Overall Completion Date:** 04/24/2025

**Update:** 04/29/2025

*please provide verification of Hipa Training completed 4/24/2025.*

17 - Record Confidentiality (continued)

Evidence of Completion

Implemented [redacted] - 07/21/2025)

See attached.

Update: 07/21/2025

Verified with documents and during an on-site POC verification completed 7/11/2025.

60a - Staff/Support Plan

3. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home had a census of 59 residents including 7 with mobility needs. Staff interviews indicated that 6 of the residents have mobility needs requiring at times assistance of two staff persons to safely transfer and evacuate during emergencies.

The home's direct care staff schedule indicates that only 2 direct care staff were working during the 3rd shift hours of 10 p.m. through 6 a.m. on 3/9/25 through 3/17/25 and on 3/22/25, from 2:30 a.m. to 6:00 a.m.

The home is not consistently scheduling an adequate number of staff persons between the hours of 10 p.m. and 6 a.m. given that seven residents require assistance of one to two staff persons to safely transfer and be evacuated during an emergency.

Plan of Correction

Accept [redacted] - 05/02/2025)

All resident mobility needs were reassessed by either the PCP or the Physical therapy group by 4/17/25. Three of the residents were on hospice and have since passed.

The schedule was updated the day of the inspection to include a third staff member on third shift. There will be a minimum of three staff members in the building at all times until there are one or less residents requiring additional assistance to evacuate.

On 4/19/25, a fire drill was conducted on third shift with 2 staff assisting residents and the 3rd staff member conducting the drill. The evacuation time was within the allowable time.

The Administrator will monitor the schedule and mobility needs of the residents weekly to ensure future compliance.

Licensee's Proposed Overall Completion Date: 04/24/2025

Update: 05/02/2025

Please provide verification of fire drill completed 4/19/2025.

Please provide verification of weekly schedule check by administrator or designee.

Evidence of Completion

Implemented [redacted] - 07/21/2025)

See attached.

60a - Staff/Support Plan (continued)

Update: 07/21/2025

Verified with documents and during an on-site POC verification completed 7/11/2025.

65f - Training Topics

4. 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.
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.

Description of Violation

Staff persons A (DOH [REDACTED]/23) and B (DOH [REDACTED]/23) did not receive training in the following required annual training topics for the 2024 training year:

- Medication self administration
- Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan
- infection control.

Plan of Correction

Accept [REDACTED] - 05/02/2025)

The documentation of the training was lacking the required training topics. Staff persons A and B were both trained in the three missing topics on 3/27/25. The Administrator will review the documentation of training after each training to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: 04/22/2025

Update: 05/02/2025

Please provide verification of training review for any trainings completed in 2025.

Evidence of Completion

Implemented [REDACTED] - 07/21/2025)

See attached.

Update: 07/21/2025

Verified with documents and during an on-site POC verification completed 7/11/2025.

65g - Annual Training Content

5. 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:

5. Falls and accident prevention.

Description of Violation

Staff persons A (DOH [REDACTED]/23), B (DOH [REDACTED] 23), and C (DOH [REDACTED]/20) did not receive training in the following required annual training topic for the 2024 training year:

65g - Annual Training Content (continued)

- Falls and accident prevention

**Plan of Correction**

Accept [redacted] - 05/02/2025)

The documentation of the training was lacking the required training topics. Staff persons A, B and C were trained on Falls and Accident Prevention on 3/20/25. The Administrator will review the documentation of training after each training to ensure on going compliance.

Licensee's Proposed Overall Completion Date: 04/22/2025

Update: 05/02/2025

Please provide verification of training review for any trainings completed in 2025.

**Evidence of Completion**

Implemented [redacted] - 07/21/2025)

See attached.

Update: 07/21/2025

Verified with documents and during an on-site POC verification completed 7/11/2025.

85a - Sanitary Conditions

6. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

**Description of Violation**

The syringe used to draw and place resident #1's Valpuric acid into a medication cup was found stored in a plastic bag in the medication cart. The plastic bag was sticky, and the syringe had some medication remaining in it from the previous use and some of the medication was stuck to the outside of the top of the syringe.

**Plan of Correction**

Accept [redacted] - 04/29/2025)

A new Med Tech was on the cart for [redacted] first solo med pass. The plastic bag, bottle and syringe were all cleaned immediately. The more experienced Med Tech was made aware. [redacted] then addressed medication storage and sanitary conditions with the new med tech and monitored [redacted] for the rest of the shift. Carts and will be checked daily for the next week then weekly for the next month by the Administrator or Designee. Monthly Cart audits will be conducted by the administrator to ensure continued compliance. The Administrator will cover Sanitary conditions at the staff training on 4/24/25. The Administrator will also cover sanitary conditions with all future Med Techs during the first cart training shift.

Licensee's Proposed Overall Completion Date: 04/24/2025

Update: 04/29/2025

Please provide verification of med cart checks and of training completed with med techs on 4/24/2025.

**Evidence of Completion**

Implemented [redacted] - 07/21/2025)

See attached.

Update: 07/21/2025

Verified with documents and during an on-site POC verification completed 7/11/2025.

103g - Storing Food

7. Requirements

2600.  
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

At 2:05 p.m. an unsealed bag of Hershey's Cocoa was observed in the home's pantry

Plan of Correction

Accept [redacted] - 04/29/2025)

The unsealed bag of Hershey's Cocoa was almost empty and disposed of at the time of the inspection. Dietary staff was retrained on proper food storage on 3/20/25. The dietary manger will conduct audits in the food storage areas weekly for six weeks. The Administrator will spot check the food storage areas at least monthly to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: 04/22/2025

Update: 04/29/2025

Please provide verification of dietary training completed 3/20/2025 and of administrator spot checks.

Evidence of Completion

Implemented ([redacted] - 07/21/2025)

See attached.

Update: 07/21/2025

Verified with documents and during an on-site POC verification completed 7/11/2025.

132h - Designated Meeting Place

8. Requirements

2600.  
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

The home conducted a fire drill on 3/14/25 at 11:20 a.m. Resident #2 was not evacuated during the drill and staff indicated that a housekeeper was asked to sit with resident #2 in their room during the drill.

Plan of Correction

Directed [redacted] - 05/02/2025)

Resident #2 was on hospice and had taken a turn earlier in the day. The letter had not been completed to allow the resident to not be evacuated during a fire drill. The staff member was placed in the room to simulate the effort to evacuate. Going forward the home has developed a standard non evacuation for a fire drill letter to be signed when hospice care begins so that it may be enacted as soon as the resident declines to the point that evacuation for a drill is not in their best interest. The administrator will audit the hospice charts within one week of hospice admission to ensure ongoing compliance.

Proposed Overall Completion Date: 04/24/2025

**Directed: The home will evacuate all residents to a fire safe area or out of the home during all fire drills**

**132h - Designated Meeting Place (continued)**

*unless all elements of regulation 29a and 29b 1-11 are satisfied.*

Directed Completion Date: 05/09/2025

Evidence of Completion

Implemented [redacted] - 07/21/2025)

N/A

Update: 07/21/2025

Verified with documents and during an on-site POC verification completed 7/11/2025.

**144c1 - Smoking Area Guidelines**

**9. Requirements**

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

**Description of Violation**

*At approximately 10:00 a.m. there were approximately 6 to 8 cigarette butts observed in the grass along the cement pathway of the rear of the home.*

**Plan of Correction**

Accept [redacted] - 05/02/2025)

*The cigarette butts were from the delivery drivers. The outside cameras were reviewed to ensure staff was following policy. Letters were mailed and phone calls were made to all vendors that deliver to that area to remind them that smoking is not permitted on the property. The administrator will inspect the delivery/service entrance weekly to ensure ongoing compliance.*

Licensee's Proposed Overall Completion Date: 04/22/2025

Evidence of Completion

Implemented [redacted] - 07/21/2025)

See attached.

Update: 07/21/2025

Verified with documents and during an on-site POC verification completed 7/11/2025.

**183b - Meds and Syringes Locked**

**10. Requirements**

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

**Description of Violation**

*At 9:05 a.m. there was an unattended medication cart observed in the D hallway that had a bottle of Fluticasone nasal spray on the cart. The medication was not locked in the cart.*

**Plan of Correction**

Accept [redacted] - 04/29/2025)

*A new Med Tech was on the cart for [redacted] first solo med pass. The cart was immediately cleared of the empty nasal spray bottle. The more experienced Med Tech was made aware. [redacted] then addressed medication storage with the new med tech and monitored [redacted] for the rest of the shift. The top drawer of all carts were cleared to allow the med techs to place empty pill packets and medication bottles in a locked area until the cart is taken back to the Nurse's*

183b - Meds and Syringes Locked (continued)

station to be disposed of properly. Carts were checked at minimum three times per day for one week then daily for the next month by the Administrator or Designee. The Administrator will cover medication storage at the staff training on 4/24/25. The Administrator will also cover medication storage with all future Med Techs during the first cart training shift. The Administrator will monitor carts weekly for ongoing compliance.

Licensee's Proposed Overall Completion Date: 04/22/2025

Update: 04/29/2025

Pease provide verification of med cart checks and of education provided to med techs.

Evidence of Completion

Implemented ( [REDACTED] - 07/21/2025)

See attached.

Update: 07/21/2025

Verified with documents and during an on-site POC verification completed 7/11/2025.

[REDACTED]

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 #5's glucometer was not calibrated to the correct date and time and indicated a current date of 1/27/25 on 3/25/25.

Plan of Correction

Accept [REDACTED] - 04/29/2025)

Resident #5 has a weekly order for testing. An order was requested to replace the glucometer for resident #5 as it was not maintaining the proper date/time on 3/28/25. The PCP discontinued the weekly testing as the resident's BG was stable and the resident is not insulin dependent. The Administrator will check all glucometers weekly to ensure they are properly calibrated to ensure on going compliance. Calibration training will be completed at the staff meeting on 4/24/25.

Licensee's Proposed Overall Completion Date: 04/24/2025

185a - Implement Storage Procedures (continued)

Update: 04/29/2025

Please provide verification of weekly checks on glucometers.

Evidence of Completion

Implemented [redacted] - 07/21/2025)

See attached.

Update: 07/21/2025

Verified with documents and during an on-site POC verification completed 7/11/2025.

225c - Additional Assessment

13. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

- 2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #2 has a bed cane attached to their bed that they have utilized since 6/20/2024. Their assessment dated [redacted]/24 does not indicate that a bed cane was being utilized by the resident.

Plan of Correction

Accept [redacted] - 05/02/2025)

The documentation for the bed cane was entered on the RASP Update for June 20, 2024 and was not transferred onto the RASP dated 10/2/2024. The RASP Update was completed at the time of the inspection. The administrator will review the RASPs monthly to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: 04/22/2025

Update: 05/02/2025

Please provide verification of updated RASP for Resident 2 and of monthly RASP audits.

Evidence of Completion

Implemented [redacted] - 07/21/2025)

See attached.

Update: 07/21/2025

Verified with documents and during an on-site POC verification completed 7/11/2025.