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

July 28, 2025

[redacted]
CLARKS SUMMIT AID II OPCO LLC
[redacted]

RE: WILLOWBROOK PLACE
150 EDELLA ROAD
CLARKS SUMMIT, PA, 18411
LICENSE/COC#: 22659

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/29/2025, 05/01/2025, 05/02/2025, 05/05/2025 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: *WILLOWBROOK PLACE* **License #**: *22659* **License Expiration**: *01/08/2026*

Address: *150 EDELLA ROAD, CLARKS SUMMIT, PA 18411*

County: *LACKAWANNA* **Region**: *NORTHEAST*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *CLARKS SUMMIT AID II OPCO LLC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/10/1996* **Issued By**: *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *44* **Waking Staff**: *33*

Inspection Information

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

Reason: *Interim* **Exit Conference Date**: *05/05/2025*

Inspection Dates and Department Representative

04/29/2025 - On-Site: [redacted]

05/01/2025 - Off-Site: [redacted]

05/02/2025 - Off-Site: [redacted]

05/05/2025 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *37*

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**: *37*

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

Have Mobility Need: *7* **Have Physical Disability**: *0*

Inspections / Reviews

04/29/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/14/2025*

Inspections / Reviews *(continued)*

06/17/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/19/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/23/2025*

07/28/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/19/2025*

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

103e - Left Overs

1. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

At approximately 10:10 a.m. a plastic container with frozen chicken fillets was noted in the first-floor freezer not labeled or dated.

At approximately 10:10 a.m. a metal container with green Jell-O was noted in the first-floor refrigerator not labeled or dated.

Plan of Correction ***Accept (06/17/2025)***

Plan of Correction:
• All unlabeled and undated food items were immediately discarded upon discovery.
• Staff will use food-safe ID stickers with the preparation date and item name for all leftover and prepared foods. Stickers will be affixed at the time of storage.
• All dietary staff will receive in-person training on proper food labeling and dating by 6/20/2025.
• Shift supervisors will verify compliance at the end of each shift.
• The Food Service Director will conduct weekly spot audits for one month and report findings to the Administrator.
Person Responsible:
Food Service Director
Completion Date:
6/20/2025
Monitoring:
Weekly audits and daily shift log checks.
• All corrective actions will be reviewed at monthly Quality Assurance (QA) meetings for three months.
• All logs, audit sheets, staff training rosters, revised forms, and purchase receipts will be retained for Department review.
• Supporting documentation will be uploaded via SansWrite or provided to DHS upon request.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented - 07/09/2025)

103g - Storing Food

2. Requirements

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

Description of Violation

At approximately 10:00 a.m. a clear plastic bag of french fries was noted opened and not sealed in the first-floor freezer.

103g Storing Food (continued)

Plan of Correction ***Accept [redacted] 06/17/2025)***

Plan of Correction:
• The open bag was sealed at discovery and all storage areas checked for similar items.
• All dietary staff will receive in person retraining by 6/20/2025 on the requirement to keep all food in closed or sealed containers.
• Visual reminders will be posted in all food storage areas.
• The Food Service Director will conduct weekly spot checks for 30 days.
Person Responsible:
Food Service Director
Completion Date:
6/20/2025
Monitoring:
Weekly spot checks documented in a log.
• All corrective actions will be reviewed at monthly Quality Assurance (QA) meetings for three months.
• All logs, audit sheets, staff training rosters, revised forms, and purchase receipts will be retained for Department review.
• Supporting documentation will be uploaded via SansWrite or provided to DHS upon request.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented [redacted] 07/09/2025)

132c - Fire Drill Records

3. 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 fire drills on [redacted] at 12:12 a.m. and on [redacted] at 2:46 p.m. The home's fire drill records did not note the number of residents evacuated during the fire drills.

Plan of Correction ***Accept [redacted] 06/17/2025)***

Plan of Correction:
• Fire drill forms were updated to require entry of the number of residents evacuated.
• All shift supervisors and the Maintenance Director will receive in person training by 6/20/2025 on proper completion of the forms.
• The Administrator will review all fire drill logs monthly for compliance.
Person Responsible:
Administrator, Maintenance Director
Completion Date:
6/20/2025

132c - Fire Drill Records (continued)

Monitoring:
Monthly audit of fire drill records.
• All corrective actions will be reviewed at monthly Quality Assurance (QA) meetings for three months.
• All logs, audit sheets, staff training rosters, revised forms, and purchase receipts will be retained for Department review.
• Supporting documentation will be uploaded via SansWrite or provided to DHS upon request.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented ([redacted] - 07/09/2025)

132h - Designated Meeting Place

4. 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

Resident[redacted] and[redacted] were receiving hospice services and were not evacuated during the fire drill conducted on [redacted] at 3:59 a.m. The home did not attempt to enact the Statement of Policy under regulation 29 a-b1 through 29 a-b11.

As per interviews with staff of the home Resident [redacted] and [redacted] were receiving hospice services and were not evacuated during the fire drill conducted on [redacted] at 12:12 a.m. The home did not attempt to enact the Statement of Policy under regulation 29 a-b1 through 29 a-b11.

Plan of Correction ***Accept([redacted] - 06/17/2025)***

Plan of Correction:
• The fire drill policy has been revised to require simulation of evacuation for hospice residents in compliance with the facility Statement of Policy and DHS guidelines.
• All staff will be trained in-person by 6/20/2025 on the revised fire drill policy and documentation procedures.
• Fire drill logs will indicate whether hospice resident evacuation was simulated, referencing policy.
• Administrator will audit all fire drill records for ongoing compliance.
Person Responsible:
Administrator
Completion Date:
6/20/2025
Monitoring:
Ongoing audit of drill logs and staff compliance.
• All corrective actions will be reviewed at monthly Quality Assurance (QA) meetings for three months.
• All logs, audit sheets, staff training rosters, revised forms, and purchase receipts will be retained for Department review.
• Supporting documentation will be uploaded via SansWrite or provided to DHS upon request.

132h - Designated Meeting Place *(continued)*

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented (- 07/09/2025)

141a 1-10 Medical Evaluation Information

5. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident Medical Evaluation dated did not include temperature; special health and dietary needs; ability to self-administer medications; and body positioning/movement.

Plan of Correction ***Accept - 06/17/2025)***

Plan of Correction:

• Resident Wellness Director ( ) will ensure all missing components are completed for Resident by 6/20/2025.

• All current resident medical evaluations will be audited for completeness; missing items will be corrected.

• The admissions checklist now requires the Resident Wellness Director to review and sign off on all new medical evaluations before filing.

• Monthly audits will be performed for new admissions' medical evaluations.

Person Responsible:

Resident Wellness Director)

Completion Date:

6/20/2025

Monitoring:

Audit results documented monthly.

• All corrective actions will be reviewed at monthly Quality Assurance (QA) meetings for three months.

• All logs, audit sheets, staff training rosters, revised forms, and purchase receipts will be retained for Department review.

• Supporting documentation will be uploaded via SansWrite or provided to DHS upon request.

Licensee's Proposed Overall Completion Date: *06/20/2025*

141a 1-10 Medical Evaluation Information *(continued)*

Implemented [redacted] - 07/09/2025)

144c1 - Smoking Area Guidelines

6. 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 10:20 a.m. 5 cushions were noted on the wicker furniture in the "courtyard" smoking area. The cushion labels indicate they are not made with fire resistant materials.

Repeat Violation: [redacted]

Plan of Correction ***Accept (- 06/17/2025)***

Plan of Correction:
• All non-compliant cushions were removed immediately.
• Fire-resistant cushions will be ordered from Flame Safe Products (flamesafeusa.com) and/or Cushion Source (cushionsource.com) with documentation of purchase retained for inspection.
• All staff will be trained in-person by 6/20/2025 on fire safety requirements for smoking area furnishings.
• Maintenance Director will inspect the smoking area weekly for compliance.
Person Responsible:
Maintenance Director
Completion Date:
6/20/2025
Monitoring:
Weekly inspection documented in maintenance logs.
• All corrective actions will be reviewed at monthly Quality Assurance (QA) meetings for three months.
• All logs, audit sheets, staff training rosters, revised forms, and purchase receipts will be retained for Department review.
• Supporting documentation will be uploaded via SansWrite or provided to DHS upon request.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented [redacted] - 07/18/2025)