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

August 18, 2025

[REDACTED], ADMINSTRATOR
MORNING GLORY SENIOR LIVING INC
419 N. QUEEN STREET
LITTLESTOWN, PA, 17340

RE: MORNING GLORY SENIOR LIVING
419 N. QUEEN STREET
LITTLESTOWN, PA, 17340
LICENSE/COC#: 31280

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/10/2025 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: *MORNING GLORY SENIOR LIVING* **License #**: *31280* **License Expiration**: *03/21/2026*

Address: *419 N. QUEEN STREET, LITTLESTOWN, PA 17340*

County: *ADAMS* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *MORNING GLORY SENIOR LIVING INC*

Address: *419 N. QUEEN STREET, LITTLESTOWN, PA, 17340*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/13/2001* **Issued By**: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *12* **Waking Staff**: *9*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *07/10/2025*

Inspection Dates and Department Representative

07/10/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *12* **Residents Served**: *12*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *12*

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

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

Inspections / Reviews

07/10/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/26/2025*

07/21/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/10/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/28/2025*

Inspections / Reviews *(continued)*

07/28/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *08/10/2025*
Reviewer: [redacted]
Follow-Up Type: *Document Submission* **Follow-Up Date**: *08/11/2025*

08/18/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *08/10/2025*
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 [redacted] at approximately 4:30 AM, staff person A reported hearing someone falling down the steps. Upon investigation, staff person A found resident #1 laying on the floor in front of the stairs. Resident #1 complained of pain in [redacted] 911 was contacted, and resident #1 was transported to the hospital. Resident #1 was diagnosed with [redacted] The home did not report this incident to the Department.

Plan of Correction ***Directed ([redacted] - 07/28/2025)***

In response to the violation on 07/10/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 07/25/2025 by the administrator to In response to the violation on 07/10/2025..

The administrator compiled a checklist that was implemented on July 15,2025 to have daily checklist, that was completed on July 16, 2025

Effective 07/11/2025 the Administrator began preforming ongoing daily checks to maintain compliance with incident reports Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

[Directed]

- *In addition to the steps above, the administrator or designee will complete and incident report for the [redacted] incident into the Department. A copy of this incident and confirmation the incident report was sent to the Department will be kept and available for review by the Department. This will be completed by 8/4/25.*

Directed Completion Date: *08/04/2025*

Implemented ([redacted] - 08/11/2025)

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

On 7/10/25, at approximately 9:10 AM, the resident privacy coding from the 7/17/24 license inspection summary was posted with the 7/17/24 license inspection summary.

Plan of Correction ***Accept ([redacted] - 07/28/2025)***

In response to the violation on 07/10/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate

17 - Record Confidentiality (continued)

action was taken on 7/10/2025 by the administrator to remove the resident privacy coding from the 7/17/24 license inspection summary which was posted with the 7/17/24 license inspection summary.

Policy procedures have been revised by the administrator on July 15, 2025

The administrator had a staff meeting on July 15, 2025 with the direct care staff reinforcing the issue of record confidentially for all residents and staffs personal information.

Effective 07/21,2025 the administrator will perform ongoing weekly walkthrough audits to ensure compliance with record confidentially., starting on 7/21/2025.

Licensee's Proposed Overall Completion Date: *07/25/2025*

Implemented (█ - 08/18/2025)

86b - Bathroom

3. 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

The ventilation fan in the bathroom located near room #2 on the first floor is inoperable, and there are no windows in the bathroom.

Plan of Correction ***Accept (█ - 07/28/2025)***

In response to the violation on 07/10/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on July11, 2025 by the Administrator to arrange for an electrician to repair or replace the ventilation fan in the bathroom located near room #2 on the first floor .The fan is to be replaced or repaired by July 30, 2025. On July 11, 2024 an audit of the ventilation fans was completed by the administrator to ensure that all fans were in working order.

To enhance the currently compliant operations, on July 24, 2025 the Administrator made up a monthly checklist for the exhaust fans to be checked by the maintenance staff .The maintenance staff were made aware of this on July 24, 2025

A quarterly building inspection will be completed by the maintenance staff person This will start on August 1, 2025 and be done every three months. The maintenance staff was made aware of this on July 24, 2025

The administrator will tell the maintenance staff that they are to do a monthly check of the exhaust fans and sign off the checklist and also do a quarterly building inspection to make sure that everything that is in the home that is run by electricity is working properly as well as what runs on natural gas. If anything is found that is not working properly if it is something that he can not repair to let an administrator know so they can get in touch with a repair person that can take care of the problem

86b - Bathroom (continued)

Licensee's Proposed Overall Completion Date: *07/25/2025*

Implemented (█ - 08/18/2025)

103f - Refrigerator/Freezer Temps

4. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 7/10/25, at 2:20 PM, the temperature in the refrigerator, located in the kitchen, was 50 degrees Fahrenheit, and the temperature in the freezer, located in the kitchen, was 4 degrees Fahrenheit. At 3:45 PM, the temperature in the refrigerator was 50 degrees Fahrenheit, and the temperature in the freezer was 2 degrees Fahrenheit.

On 7/10/25, at 2:55 PM, the temperature in the stand-up freezer, located in the basement, was 20 degrees Fahrenheit. At 4:00 PM, the temperature in the stand-up freezer was 10 degrees Fahrenheit.

Plan of Correction ***Accept (█ - 07/28/2025)***

On July 10, 2025 the refrigerator and freezer were immediately checked by the administrator.All perishable food was inspected, any food potentially affected by temperature deviation was discarded as a precaution. A service technician was called on July 11,2025 and the refrigerator and freezer were repaired on July 11, 2025.

Staff have been retrained on proper food storage temperatures and daily temperature logging in procedures.A refrigerator/freezer log was implemented on July 11, 2025 requiring staff to document temperatures twice daily.
The administrator will review the temperature logs.weekly.If temperatures fall outside the acceptable range, the staff are required to notify the administrator immediately and follow the food safety protocol which included discarding unsafe items.
Administrator is responsible for ensuring all refrigerators and freezers remain i compliance and that temperature logs are maintained and reviewed regularly.

The staff was retrained on July 11, 2025 by the administrator.

The administrator started the weekly reviews on July17, 2025.

Licensee's Proposed Overall Completion Date: *07/24/2025*

Implemented (█ - 08/18/2025)

141a - Medical Evaluation

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.

Description of Violation

Resident #2 was admitted to the home on [redacted] However, the resident's initial medical evaluation was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 07/28/2025)***

Upon review it was identified that the residents medical evaluation dated [redacted] was completed 61 days prior to admission on [redacted] and therefore did not meet the required timeline. This was an unintentional oversight. The administrator reviewed the residents admission file and confirmed all other documentation was complete and accurate. No resident harm occurred as a result of this delayEffective immediately, a revised pre-admission checklist has been implemented to flag the 60-day window for all medical evaluations. All future medical evaluations will be reviewed by the administrator or designee prior to admission to confirm they fall within the regulatory time frame. Ifthe evaluation is nearing expiration, a new one will be requested before proceeding with admission.
The administrator will review all pre-admission documentation as part of the standard admission approval process. A compliance review will be conducted monthly to ensure all admissions within the month met the required timeline. A log will be maintained for auditing purposes.
Administrator, [redacted] is responsible for overseeing all admissions and ensuring all medical evaluations are dated in compliance with the regulation 2
600.14

In response to the violation on 07/10/2025 by the Pennsylvania Bureau of Human Service Licensing, the Administrator who is responsible for overseeing the completed residents medical evaluation forms was given a review all of the residents medical evaluations requirements by the Licensing representative [redacted] - [redacted] be sure they were in compliance with the regulations. This was done on July 10. 2025 .

Proposed Overall Completion Date: 07/25/2025

Licensee's Proposed Overall Completion Date: *07/25/2025*

Implemented ([redacted] - 08/11/2025)

141b1 - Annual Medical Evaluation

6. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #1's most recent medical evaluation, dated [redacted], did not include immunization history.

Plan of Correction ***Accept ([redacted] - 07/28/2025)***

Upon discovery, the residents primary care provider was contacted and the immunization history was obtained and added to the residents current medical evaluation form. The completed documentation was placed in the

141b1 - Annual Medical Evaluation (continued)

residentsmedical file on July 11, 2025.The facilities medical evaluation process has been revised to include a mandatory completeness check before a form is accepted as final. The checklist now ensures that all required sections of the annual medical evaluation, including immunization history, are fully completed and signed by the healthcare provider.
Thew administrator or designee will review all medical evaluations upon receipt to ensure full compliance .2600.141. An annual audit of medical records will be conducted to verify that immunization histories are present for all residents. Any forms missing required information will be returned immediately to the provider for completion. The administrator [redacted] is responsible for overseeing compliance with all resident medical documentation requirements.

In response to the violation on 07/10/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 07/11/2025 by the Administrator to compile a mandatory completeness check before the medical evaluation is accepted as final. The medical evaluation will be reviewed by the administrator and an administrator designee to be sure that the medical evaluation was filled out completely.

The checklist will start on August 1, 2025 and will be done monthly on the first day of each month.

An initial audit of all current medical evaluations will be completed on July 30, 2025. The administrator will take care of this.

An annual audit will take place on January 2, 2026 and will be ongoing on January 2, each year thereafter

On July 10, 2025 the Licensing representative [redacted] reviewed with the Administrator the importance of having the medical evaluation filled out completely and to check and be sure that each section is filled out.

Proposed Overall Completion Date: 07/25/2025

Licensee's Proposed Overall Completion Date: *07/25/2025*

Implemented ([redacted] - 08/18/2025)

181c - Self-administration Assessment

7. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #1 self-administers Calmoseptine ointment; however, resident #1 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Plan of Correction ***Accept ([redacted] - 07/28/2025)***

On July 11, 2025 the residents physician was contacted and an assessment to determine the resident's ability to self-administer medication was completed. The physician signed the required assessment documentation confirming

181c - Self-administration Assessment (continued)

the resident is capable of safely self-administering Calmoseptine ointment. The documentation been placed in the residents medical record.Effective immediately, the medication administration records and care plans for all residents who self-administer and medications (including ointments, creams, or over the counter products) will be reviewed to ensure appropriate assessment in place. A new step has been added to the medication review process to confirm that physician assessments are completed before residents begin self administration of any substance classified as a medication.

An initial audit that will ensure that all other residents who self-administer their medications are able to do so was be done by direct on July 15, 2025 and was completed by July 22,2025.

All direct staff have been retrained by the administrator on July 15, 2025 on the importance of having documentation form the residents physician stating that the resident can self administer a medication.

The new step was added on July 15,2025

The direct care staff will have a quarterly review of the residents who are self administering to be sure that they can still do so. The quarterly review will begin on August 1, 2025 and every three months there after on the first day of the month.

Proposed Overall Completion Date: 07/30/2025

Licensee's Proposed Overall Completion Date: *07/30/2025*

Implemented (█ - 08/18/2025)

183d - Prescription Current

8. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 7/10/25, Hydrocortisone 1% prescribed for resident #4, was in the home's medication cabinet; however, this prescription was changed to Hydrocortisone 2.5% cream.

Plan of Correction ***Accept (█ - 07/28/2025)***

The administrator confirmed that Hydrocortizone 1% cream remained in residents #4's medication storage after the prescription was changed to Hydrocortizone 2.5%. the outdated medication was immediately removed and properly discarded according to facilities policy.
Effective immediately , all discontinued or outdated medications will be removed from the medication cabinet by the med tech and or designee at the time the prescription is changed, and the documentation on the MAR's.
A weekly medication cabinet review has been implemented to ensure that only active, current prescriptions remain in the home. Discontinued or expired medications will be identified and disposed of per pharmacy return policy or destruction protocol.
All direct care staff received re-education on 2600.183(d), with emphasis on the requirement to remove discontinued medications promptly to prevent potential medication errors.

183d - Prescription Current (continued)

Medication audits will be completed weekly by the administrator for the next 30 days and monthly for three months after.

The weekly medication cabinet checks began on July 16, 2025 by the direct care staff.

The administrator educated the direct care staff on July 15, 2025

The weekly medication audits are done weekly on each Monday starting July 21, 2025

Proposed Overall Completion Date: 07/30/2025

Licensee's Proposed Overall Completion Date: *07/30/2025*

Implemented (- 08/18/2025)

184a - Resident's Meds Labeled

9. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

The pharmacy label for resident #1's Systane eye drops does not include the instructions for administration.

The pharmacy label for resident #2's Aspirin 81mg, Tylenol arthritic and multivitamins did not include the instructions for administration.

The pharmacy label for resident #3's PRN Lactaid did not include the instructions for administration.

The pharmacy label for resident #4's Loperamide 2mg did not include the instructions for administration.

Plan of Correction ***Accept (- 07/28/2025)***

The administrator reviewed all pharmacy-labeled prescription medications and confirmed that multiple containers did not include the required instructions for administration. This included #1,#2,#3, and #4.
The affected prescriptions were returned to the pharmacy with the request for corrected labels that include full dosage and administration instructions,Corrected containers were received and placed back into circulation.

184a - Resident's Meds Labeled (continued)

Moving forward, all incoming prescription medications will be reviewed the by the med tech or designee at the time of delivery to ensure the pharmacy label is complete and compliant. A new medication checklist has been implemented to verify:
Resident Name
Drug name and strength
Dosage
Route
Frequency and admiration instructions
If a label is incomplete or missing instructions, the pharmacy will be contacted immediately and the medication will not be administered until then late is corrected.
In-service education will be conducted for all med techs and administrative staff, by 07/30/2025 to review proper medication labeling protocols and DHS regulations.
The administrator will audit medication charts weekly for 30 days to ensure full label compliance.

The administrator completed the official audit on July 15, 2025 and returned the prescriptions to the pharmacy on July 16, 2025.

The prescriptions were returned on July 17, 2025.

The administrator had an inservice education on the proper label on medications on July 15, 2025.

The medication audits will be conducted weekly on each Monday by the 11p-7a direct care staff and they will sign off on a checklist This will begin on July 21, 2025.

Proposed Overall Completion Date: 07/30/2025

Licensee's Proposed Overall Completion Date: *07/30/2025*

Implemented (- 08/18/2025)

185a - Implement Storage Procedures

10. 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 #1 is prescribed Elecon .01% cream and Mucinex as needed. However, on 7/10/25, these medications were not available in the home.

Resident #3 is prescribed Mucinex as needed. However, on 7/10/25, this medication was not available in the home.

Plan of Correction ***Accept (- 07/28/2025)***

The administrator confirmed that Elecon cream and Mucinex were not available to the residents #1 and #3 as prescribed. This issue was immediately addresses by obtaining both medications and ensuring that they were

185a - Implement Storage Procedures (continued)

placed into the secured medication storage are for use.
A Medication Availability Log has been implemented and will be completed by the Direct Care staff at the start of each shift. This ensures that all prescribed medications, including PRN's, are present, labeled, and within expiration.
The administrator has also added a PRN Reorder Reminder System to the medication charting process. This includes a visual flag in the MARS and a weekly check-in with the pharmacy to verify low and missing PRN's.
All Direct Care staff received re-education on medication availability procedures, including the importance of preemptively notifying the administrator or pharmacy when the stock is low.
The administrator will conduct weekly medication chart checks for 30 days then monthly for three months to ensure continued compliance.

In response to the violation on 07/10/2025 by the Pennsylvania Bureau of Human Service Licensing,, immediate action was taken on 07/11/2025 by the administrator fby sending over an order for the Elecon cream and the mucinex.. The meds were delivered oh July 12, 2025

The medication availability log was implemented on July 15, 2025 . The direct care staff were re-educated on July 15, 2025 by the administrator.

The weekly audits begin on July 21, 2025.

Proposed Overall Completion Date: 07/30/2025

Licensee's Proposed Overall Completion Date: *07/30/2025*

Implemented (- 08/18/2025)

187d - Follow Prescriber's Orders

11. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #1 is prescribed Melatonin 5mg with orders to take daily at bedtime. However, medication was not administered to resident #1 on 7/3/25 and 7/5/25 at 8:00 PM.

Resident #2 is prescribed blood sugar checks four times a day or as directed. However, as of 7/1/25, the home has been completing blood sugar checks on resident #2 once a day.

Resident #4 is prescribed Carvedilol 25mg with orders to take twice daily and to hold if heart rate/pulse is <60. On 7/4/25, at 8:00 AM, the resident's pulse was 57, and the medication was administered. On 7/9/25, at 8:00 AM, the resident's pulse was 58, and the medication was administered.

Repeated Violation - 7/17/24

187d - Follow Prescriber's Orders *(continued)*

Plan of Correction ***Accept (- 07/28/2025)***

The administrator immediately reviewed the medication administration records (MARS) and physician orders for Resident #1, #2, and #4. Staff responsible for the identified omission and errors were concealed individually and re-educated on the importance or following prescriber instructions without deviation.
Resident #1, a system has been put in place to verify all bedtime medications are signed off by 9:00 pm daily, with cross verification with overnight direct care staff.
Resident #2, blood sugar monitoring protocols were reviewed with all med techs, and the residents diabetic care schedule has been re-posted at the medication chart (MARS)
Resident #4, staff have been retrained specifically on pulse parameters for medication administration. A new Medication Hold Alert Sticker System has been implemented to clearly flag medications with conditional administration requirements (e.g.,hold pulse if <60).
A mandatory Medication Administration in-service will be conducted far all direct care staff by (July 30,2025) and new hires will now receive training on the regulation during onboard training. the administrator or designee will conduct weekly medication audits for the next 60 days to ensure full compliance.

Resident 1 system was put in place on July 10, 2025

Blood sugar monitoring was reviewed with the direct care staff on July 15, 2025 by the administrator.

The direct care staff were retrained by the administrator on July 15, 2025 on the parameters of the medication administration .

The administrator is responsible for medication administration in-services.

The weekly med audits will begin on July 21, 2025

Proposed Overall Completion Date: 07/30/2025

Licensee's Proposed Overall Completion Date: *07/30/2025*

Implemented (- 08/18/2025)

225c - Additional Assessment

12. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #3's current medical evaluation, dated includes the following diagnoses: weakness on the right side, Atrial Fibrillation (AFIB), hypertension, hyperlipidemia, gait difficulty and Chronic Respiratory Disease (CRD). However, resident #3's current assessment, dated , does not include these diagnoses.

Repeated Violation - 7/17/24

225c - Additional Assessment *(continued)*

Plan of Correction ***Accept (- 07/28/2025)***

The administrator reviewed resident #3's most recent medical evaluation date and confirmed that the diagnosis of weakness right side, atrial fibrillation, hypertension, hyperlipidemia, gait difficulty, and chronic repository disease were not reflected in the resident's assessment.
The assessment was immediately updated to include all relevant diagnosis from the current medical evaluation.
A new protocol has been implemented requiring all medical evaluations to be cross-referenced with residents assessments upon admission and during quarterly reviews. Direcr care staff and the administrator/designee will review each residents diagnosis list against the current medical evaluation ensure accuracy.
In-service training will be provided to all direct care and administrative staff by 07/30/2025 on proper assessment documentation procedures and compliance with 2600.225(c)
Responsible party Administrator

The new protocol was implemented on July 15, 2025

The quarterly reviews will be made on the first day of the month starting on August 1, 2025 and every three months after that date.

In-service training date was July 15, 2025.

All current rasp will be audited by July 30,2025 by the administrator and the direct care staff.

Proposed Overall Completion Date: 07/30/2025

Licensee's Proposed Overall Completion Date: *07/30/2025*

Implemented (- 08/18/2025)