Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

September 11, 2025

[REDACTED], OWNER
NT ROSE HAVEN LLC
132 HAVEN DRIVE
INDIANA, PA, 15701

RE: ROSE HAVEN
132 HAVEN DRIVE
INDIANA, PA, 15701
LICENSE/COC#: 45429

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/22/2025, 08/04/2025 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: *ROSE HAVEN* **License #**: *45429* **License Expiration**: *03/24/2026*

Address: *132 HAVEN DRIVE, INDIANA, PA 15701*

County: *INDIANA* **Region**: *WESTERN*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *NT ROSE HAVEN LLC*

Address: *132 HAVEN DRIVE, INDIANA, PA, 15701*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/02/2007* **Issued By**: *Dept. of Labor & Industry*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *08/04/2025*

Inspection Dates and Department Representative

07/22/2025 - On-Site:

08/04/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *43* **Residents Served**: *23*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *23*

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

Have Mobility Need: *2* **Have Physical Disability**: *0*

Inspections / Reviews

07/22/2025 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/05/2025*

09/08/2025 - POC Submission

Submitted By: **Date Submitted**: *09/09/2025*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/15/2025*

Inspections / Reviews *(continued)*

09/09/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *09/09/2025*
Reviewer: [redacted]
Follow-Up Type: *Document Submission* **Follow-Up Date:** *09/12/2025*

09/11/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *09/09/2025*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

85d - Trash Receptacles

1. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 7/22/25 at 10:36a.m. there was a partially full, uncovered, unattended trash can in common shower room #2.

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

The Trash can in the common shower room #2 did not have a lid. A lid was placed on day of inspection by the Maintenance Director. (photos attached) This regulation is very important to prevent the penetration of insects and rodents .
The Housekeeper /Administrator to ensure ongoing compliance by ensuring there are lids on all trash cans in the Kitchen and bathrooms. To ensure ongoing compliance audits will be done daily for 2 weeks, once a week for two weeks, weekly for two weeks, by the Director of Housekeeper/Administrator. Copies of audits are attached and will be kept in the Administrators office. All staff were in-serviced on this regulation on 7-23-25 (copy attached). Training sheets kept in Administrators office. Administrator to monitor and ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *09/08/2025*

Implemented (- 09/11/2025)

105g - Lint Removal and Duct Cleaning

2. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer’s instructions.

Description of Violation

On 7/22/25 at 10:14a.m. there was lint in the lint trap of the small residential dryer. There were no clothes in the dryer at the time.

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

Plan of Correction
During inspection a layer of lint was found in the lint trap of the small residential dryer. There were no clothes in the dryer at the time as that staff person would empty the lint trap before putting in the next load of clothes.
Staff at the time it was found removed the lint and checked all dryers.
Administrator will be responsible to ensure all staff hired are trained to empty lint traps after each load of clothes being dried.
To ensure ongoing compliance audits will be done daily for 2 weeks, once a week for two weeks, weekly for two weeks, by the Housekeeper/Administrator. Copies of audits are attached and will be kept in the Administrators office. All staff were in-serviced on this regulation on 7-23-25 (copy attached). Administrator to monitor and ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *09/08/2025*

Implemented (- 09/11/2025)

132d - Evacuation

3. 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 evacuation time of 7 minutes and 47 seconds on 12/17/24 at 12:30p.m. exceeded the maximum safe evacuation time of 6 minutes and 45 seconds as determined by a fire safety expert on 3/18/24.

During the following fire drills, not all residents of the home were evacuated to a fire-safe area designated in writing within the past year by a fire safety expert:
On 3/18/24 at 10:30a.m. there were 14 residents in the home and only 13 residents were evacuated.
On 4/19/24 at 2:36p.m. there were 15 residents in the home and only 13 residents were evacuated.
On 10/30/24 at 3:50p.m. there were 15 residents in the home and only 13 residents were evacuated.
On 12/17/24 at 12:30p.m. there were 18 residents in the home and only 17 residents were evacuated.
On 1/21/25 at 5:45a.m. there were 19 residents in the home and only 18 residents were evacuated.

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

This first part of the violation occurred due to past administration not following what the fire safety expert had determined the time limit to evacuate Residents to a public thoroughfare, or to a fire-safe area that was in writing of 6 minutes and 45 seconds. The second part of the violation occurred because all residents were not evacuated, and we believe that they may have been residents as reports show that there were Residents on hospice on the census on those dates.
The current Administrator had met with the maintenance person doing the drills and was told all residents are to be evacuated unless is told by Administrator any exceptions. Administrator has been reviewing all documentation of the logbooks, and the drills have been done correctly from February of 2025 until current August 2025. Maintenance or Administrator will do the fire drills. Administrator is responsible to ensure all drills follow this regulation. Administrator was in serviced on 7-23 on the regulation. (copy attached). Copies of Inservice will be kept in the Administrators office. If the home has a Resident on Hospice and cannot evacuate the home will follow all parts of regulation 29B and the documentation will be kept with the fire drill log. Administrator auditing the fire drill log immediately after each fire drill to ensure all residents evacuated. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/08/2025*

Implemented (- 09/11/2025)

161d - Dietary Needs

4. Requirements

2600.
161.d. A resident’s special dietary needs as prescribed by a physician, physician’s assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident’s special dietary needs shall be kept in the resident’s record.

Description of Violation

Resident #1 is prescribed small bite sized, mechanical soft food and a nectar thick liquid diet. However, on 7/22/25 at 12:17p.m., the resident was served a whole ham and cheese sandwich on a hamburger bun and a package of saltine crackers with soup.

161d - Dietary Needs (continued)

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

This violation happened because the resident was served a whole ham and cheese sandwich on a hamburger bun and a package of saltine crackers with soup.
On 7/22/25, immediately after the violation was identified, Resident #1 was provided with the appropriate mechanical soft meal as prescribed.
Measures Put in Place to Ensure Compliance for All Residents As of 7/23/25, all resident diet orders were reviewed and cross checked against current physician orders to ensure accuracy. On 7/23/25, the cook was educated on 2600.161.d dietary compliance and the importance of following physician prescribed diets.
The Administrator or designee will conduct random weekly meal service audits for 4 weeks to ensure residents are receiving appropriate diets. After 4 weeks, audits will continue monthly X 2 and results will be documented on the dietary order audit sheet. Any errors identified will be immediately corrected, and corrective action will occur. The Administrator is responsible for overall implementation and compliance.
The Kitchen Manager/Lead Cook is responsible for daily dietary adherence.
The Direct Care Staff are responsible for verifying residents' meal is correct.
Corrective action was initiated on 7/22/25 and fully implemented by 7/24/25.
Ongoing monitoring and staff education will continue to ensure long term compliance.
IN-Service completed by Administrator

Licensee's Proposed Overall Completion Date: *09/08/2025*

Implemented (- 09/11/2025)

162c - Menus Posted

5. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 7/22/25 at 11:54a.m., the only menu posted was for the current week ending 7/26/25.

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

On 7-22 only menu posted was for the current week ending 7-26-25.
When this was found the cook posted the next weeks menu. We are not sure if a Resident or family member removed the menu from the board to look at it.
The cook was in serviced on 7-23 and are attached. The training will be kept in the Administrators office. To prevent this from happening again a locked cabinet was purchased so menus cannot be removed. It is the cooks responsibility to post the menu current and 1 week in advance. Inservice was completed by Administrator copy attached

Licensee's Proposed Overall Completion Date: *09/08/2025*

Implemented (- 09/11/2025)

181c - Self-administration Assessment

6. 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 #2's annual resident assessment and support plan, dated [redacted], indicates the resident cannot self-administer medications. However, on 7/22/25 at 3:42p.m. Nystatin Powder, apply topically to affected area 2x daily, was in resident #2's bedroom.

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

Resident #2's annual resident assessment and support plan, dated [redacted], indicates the resident cannot self-administer medications. However, on 7/22/25 at 3:42p.m. Nystatin Powder, apply topically to affected area 2x daily, was in resident #2's bedroom.
This violation happened because the resident was in the hospital and upon discharge the hospital gave [redacted] what they were using while hospitalized and packed with [redacted] belongings. The home was unaware that the Resident had this and when inspectors told us about it we checked discharged orders and there was an order to continue this medication. The medication was in our Med Cart. To prevent this from happening in the future all discharges back to our home from Hospital or skilled facility, the med tec or aide are to go through all items in their bags and remove any medications and give to the Med Techs to see if the medication is to continue or not. If the medication is to continue Med tec to contact pharmacy to put the Medication on the MAR. If the medication is not to continue it is to be destroyed properly as per the homes policy and procedures. It is the responsibility of the Med Tech/ Aid to ensure no medications are in a resident room. All staff were in serviced on 7-23 on this regulation. (copy attached) Training paperwork is kept in the Administrators office. Administrator is to monitor for compliance of any resident returning to the home from Hospital or Skilled. Administrator or designee will review discharge orders to ensure all current medications are present in the medication cart, all discontinued medications are discarded and all new medications are promptly ordered to start 7-23-25

Licensee's Proposed Overall Completion Date: *09/08/2025*

Implemented ([redacted] - 09/11/2025)

183d - Prescription Current

7. 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 7/22/25 at 3:42p.m., a bottle of HySept 50 0.50% Sodium Hypochlorite Solution was in resident #2's bedroom with a label indicating it was filled on 6/26/25. However, there is no current prescription for this medication.

183d - Prescription Current *(continued)*

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

On 7/22/25 at 3:42p.m., a bottle of HySept 50 0.50% Sodium Hypochlorite Solution was in resident #2's bedroom with a label indicating it was filled on 6/26/25. However, there is no current prescription for this medication. This violation happened because the resident was in the hospital and upon discharge the hospital gave what they were using while hospitalized and packed with belongings. The home was unaware that the Resident had this and when inspectors told us about it we checked discharged orders and there was no order to continue this medication. To prevent this from happening in the future all discharges back to our home from Hospital or skilled facility, the med tec or aide are to go through all items in their bags and remove any medications and give to the Med Tecs to see if the medication is to continue or not. If the medication is to continue Med Tech to contact pharmacy to put the Medication on the MAR. If the medication is not to continue it is to be destroyed properly as per the homes policy and procedures. It is the responsibility of the Med Tech/ Aid to ensure no medications are in a resident room. All staff were in serviced on 7-23 by Administrator on this regulation. (copy attached) Training paperwork is kept in the Administrators office. Administrator is to monitor for compliance of any resident returning to the home from Hospital or Skilled. Administrator or designee will review discharge orders to ensure all current medications are present in the medication cart, all discontinued medications are discarded and all new medications are promptly ordered begin date 7-23

Licensee's Proposed Overall Completion Date: *09/08/2025*

Implemented (- 09/11/2025)

225a - Assessment 15 Days

8. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #3 receives PT/OT and speech therapy though Home Health. However, the contact information for this formal support is not indicated on the resident's initial assessment, dated

Plan of Correction ***Accept (- 09/08/2025)***

This violation happened because the Resident receives PT/OT and speech therapy through Home Health. The contact information for this formal support is not indicated on the residents initial assessment, dated All phone numbers for Home Health, Hospice and physicians is posted above the med carts in the med room for easy access to the med tecs. They RCC who was doing the support plans has left employment. The Administrator for now is doing all care plans for now. The new RCC is being trained in how to do the care plans with all information being filled out. The Care plan for Resident #3 was updated with the correct information on an addendum. (copy attached). The Administrator and the Consultant have completed an audit of Assessments of all residents. If there was any information missing an addendum was completed and attached. The administrator is responsible to ensure that all information is put on the Assessment when completed and that any new information will be done on an addendum with contact numbers for services.

Licensee's Proposed Overall Completion Date: *09/04/2025*

Implemented (- 09/11/2025)

227c - Support Plan Revision

10. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #2's annual assessment, dated [redacted] indicates the resident uses a C-Pap machine. However, [redacted] annual support plan, dated [redacted] does not include a plan to meet this need or the responsible party.

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

I respectfully request that this violation be removed. for the following reason:
The description of this violation happened because the inspectors state [redacted] initial support plan dated [redacted] does not include a plan to meet this need or the responsible party. When reviewing the support plan, it does state in the medical diagnosis of [redacted] has sleep apnea: In the plan to meet medical need, it states DCS will follow all doctors' orders monitor document and report any changes to PCP , Frequency is marked daily, Responsible party marked DCS. The MAR states use as needed per resident needs as needed
They RCC who was doing the support plans has left employment. The Administrator for now is doing all care plans. . The new RCC is being trained in how to do the care plans with all information being filled out. The Care plan for Resident #3 was updated with an addendum. (copy attached). The Administrator and the Consultant have completed an audit of Support plans of all residents. If there was any information missing an addendum was completed and attached. The administrator is responsible to ensure that all information is put on the Support plan when completed and that any new information will be done on an addendum. Administrator will be training the new RCC and the Administrator will be responsible for reviewing all Support plans before being put in the Resident chart.

Licensee's Proposed Overall Completion Date: *09/08/2025*

Implemented ([redacted] - 09/11/2025)