



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **LASOSKYS PERSONAL CARE HOME INC**
LEGAL ENTITY

To operate **LASOSKY'S PERSONAL CARE HOME, INC.**
NAME OF FACILITY OR AGENCY

Located at **23 MAIN STREET, PO BOX 27 CLARKSVILLE, PA 15322**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **25**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: _____

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **September 17,** **2025** until **March 17,** **2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **418581**

Janette Biderup
ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.



Pennsylvania Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: SEPTEMBER 17, 2025

[REDACTED]
Lasosky's Personal Care Home, Inc.
[REDACTED]

RE: Lasosky's Personal Care Home, Inc.
23 Main Street, P.O. Box 27
Clarksville, Pennsylvania 15322
License: 418581

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection on May 30, 2025 and July 28, 2025 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 45370) dated February 22, 2025 to February 22, 2026, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2); (3); (4); (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and September 17, 2025 to March 17, 2026.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[REDACTED]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, PA 17105-2675
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,



Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

[REDACTED]

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

Facility Information

Name: *LASOSKY'S PERSONAL CARE HOME, INC.* License #: *41858* License Expiration: *02/22/2026*
Address: *23 MAIN STREET, PO BOX 27, CLARKSVILLE, PA 15322*
County: *WASHINGTON* Region: *WESTERN*

Administrator

Name: [REDACTED]

Legal Entity

Name: *LASOSKYS PERSONAL CARE HOME INC*
Address: [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: Total Daily Staff: *22* Waking Staff: *17*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint* Exit Conference Date: *06/03/2025*

Inspection Dates and Department Representative

05/30/2025 - On-Site: [REDACTED]
06/02/2025 - Off-Site: [REDACTED]
06/03/2025 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *25* Residents Served: *22*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *5* Are 60 Years of Age or Older: *19*
Diagnosed with Mental Illness: *9* Diagnosed with Intellectual Disability: *2*
Have Mobility Need: *0* Have Physical Disability: *0*

Inspections / Reviews

05/30/2025 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *06/22/2025*

06/25/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: *07/06/2025*
Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *07/01/2025*

07/01/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: *07/06/2025*
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *07/07/2025*

09/09/2025 - Document Submission

Submitted By: [REDACTED] Date Submitted: *07/06/2025*
Reviewer: [REDACTED] Follow-Up Type: *Enforcement*

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On several occasions, numerous staff persons and residents have reported numerous allegations of abuse to staff person A, the home's manager, to include vulgar language from staff persons towards residents, direct care staff persons yelling and swearing at residents and a direct care staff person coercing a resident to use vulgar language towards another resident; however, none of the allegations of abuse were reported to the local Area Agency on Aging.

Plan of Correction

Directed (████ - 07/01/2025)

Act 13 form completed and given to AAA on 5/30/2025.

Manager denies any staff reporting this to █████, however █████ was educated to immediately report any abuse allegations to administrator. All residents were interviewed and also denied any of these allegations. Ombudsman was called to schedule an abuse and reporting mandates training with all staff. Training was completed on 6/27/2025 at 1 PM Hospice staff development trainer. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. █████ 7/1/25). Administrator will interview 3 residents and 2 staff persons █████ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. The resident/staff interviews shall be conducted weekly for 1 month then monthly thereafter. The interviews shall also be conducted in private and documentation of the interviews shall be kept for 1 month. █████ 7/1/25) to assess abuse. Interviews were started June 19, 2025. Quality management meeting will be held on July 3, 2025 to include all items in 2600.26b. Minutes will be kept on file.

DIRECTED: Beginning on 7/7/25: The administrator/designee shall review all internal incidents daily to ensure all allegations of abuse are immediately reported to the Area Agency on Aging in accordance with 2600.15a. █████ 7/1/25

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/07/2025

Not Implemented (████ - 09/09/2025)

16c - Written Incident Report

2. 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 several occasions, numerous staff persons and residents have reported numerous allegations of abuse to staff person A, the home's manager, to include vulgar language from staff persons towards residents, direct care staff persons yelling and swearing at residents and a direct care staff person coercing a resident to use vulgar language towards another resident; however, none of the allegations of abuse were reported to the Department.

16c - Written Incident Report (continued)

Plan of Correction**Directed** [REDACTED] - 07/01/2025)

Rec'd a call from DHS on 05/27/2025 stating there were allegations of abuse. Incident report was completed and submitted to DHS immediately.

Manager denies any staff reporting this to [REDACTED], however [REDACTED] was educated to immediately report any abuse allegations to administrator. All residents were interviewed and also denied any of these allegations. Ombudsman was called to schedule an abuse and reporting mandates training with all staff if the ombudsman does not respond within 1 week OSPTA hospice will conduct training. Training was completed on June 27, 2025 at 1 PM by Hospice Staff development trainer. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 7/1/25). Included in trainings are timeliness of reportable incidents. Administrator to interview manager and supervisors weekly for 2 months and then quarterly thereafter to assess any reportable incidents.

Quality management meeting scheduled for 7/03/2025 addressing all items in 2600.26b. Minutes to be kept on file. Administrator will interview 3 residents and 2 staff persons [REDACTED] (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. The resident/staff interviews shall be conducted weekly for 1 month then monthly thereafter. The interviews shall also be conducted in private and documentation of the interviews shall be kept for 1 month. [REDACTED] 7/1/25) to assess abuse. Interviews have started on 6/19/2025. Administrator will discuss with manager or supervisor daily for one month beginning 06/26/25 to assess any reportable incidents for and then monthly thereafter

DIRECTED: Beginning on 7/7/25: The administrator/designee shall review all internal incidents daily to ensure all incidents specified in 2600.16a, to include allegations of abuse/neglect, are reported to the Department within 24 hours in accordance with 2600.16c. [REDACTED] 7/1/25

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/07/2025

Not Implemented [REDACTED] - 09/09/2025)

18 - Compliance With Laws

3. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Adult Protective Services Act 70 of 2010 requires an employee or an administrator who has reasonable cause to suspect that a resident is a victim of abuse or neglect to immediately make an oral report to the local contracted provider of protective services agency.

On several occasions, numerous staff persons and residents have reported numerous allegations of abuse to staff person A, the home's manager, to include vulgar language from staff persons towards residents, direct care staff persons yelling and swearing at residents and a direct care staff person coercing a resident to use vulgar language towards another resident; however, none of the allegations of abuse were reported to the local contracted provider of protective services agency.

18 - Compliance With Laws (continued)

Plan of Correction

Directed [REDACTED] - 07/01/2025)

Act 13 form completed and given to adult protective services on 5/30/2025.

Manager denies any staff reporting this to [REDACTED], however [REDACTED] was educated to immediately report any abuse allegations to administrator. All residents were interviewed and also denied any of these allegations. Ombudsman was called to schedule an abuse and reporting mandates training with all staff if the ombudsman does not respond within 1 week OSPTA hospice will conduct training. Training was completed on 6/27/2025 at 1 PM by Hospice staff development trainer. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 7/1/25). Administrator will interview 3 residents and 2 staff persons [REDACTED] (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. The resident/staff interviews shall be conducted weekly for 1 month then monthly thereafter. The interviews shall also be conducted in private and documentation of the interviews shall be kept for 1 month. [REDACTED] 7/1/25) to assess abuse. Interviews began on 6/19/2025. Quality management meeting scheduled for 7/03/2025 addressing all items in 2600.26b. Minutes to be kept on file.

DIRECTED: Beginning on 7/7/25: The administrator/designee shall review all internal incidents daily to ensure all allegations of abuse are immediately reported to Adult Protective Services in accordance with the Adult Protective Services Act 70 of 2010. [REDACTED] 7/1/25

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/07/2025

Not Implemented [REDACTED] - 09/09/2025)

42b - Abuse

4. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Numerous residents and staff persons indicate that on an almost daily basis, direct care staff persons B, C, D and E yell and swear at numerous residents.

On numerous occasions, resident #1 has been told by direct care staff person B to retrieve direct care staff person B's personal laundry basket from their vehicle so direct care staff person B can do their personal laundry while working in the home. When requested, resident #1 complied and went to retrieve the laundry from direct care staff person B's vehicle.

Direct care staff person B routinely called resident #1 vulgar names, swore at resident #1, and said things like "we are having shit for supper today", "suck my titty" and called resident #1 "cuddy".

On numerous occasions, resident #2 has been denied drinks by numerous staff persons due to resident #2 being incontinent of bladder.

According to numerous residents and staff persons, direct care staff persons B and E have routinely called resident #5 names such as "fat", "lazy" and "nasty".

42b - Abuse (continued)

According to numerous residents and staff persons, direct care staff person B routinely instructed resident #6 to sit on resident #2's lap and for resident #6 to kiss resident #2. Direct care staff person B has also told resident #6 to tell resident #2 that [REDACTED] has a nice [REDACTED] on numerous occasions and has instructed resident #6 to tell resident #2 [REDACTED] is "cuckoo" on numerous occasions.

Plan of Correction**Directed [REDACTED] - 07/01/2025)**

Resident 1 was interviewed and stated that [REDACTED] likes to help and offered to carry the basket. Resident 2 is not incontinent of bladder and also denies these allegations. Manager denies any staff reporting this to [REDACTED]. All residents involved were interviewed by administrator and denied these allegations. Ombudsman was called to schedule an abuse and reporting mandates training with all staff if the ombudsman does not respond within 1 week OSPTA hospice will conduct training. Training was completed on 6/27/2025 at 1 PM by Hospice staff development trainer. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 7/1/25). Administrator will interview 3 residents and 2 staff persons [REDACTED] (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. The resident/staff interviews shall be conducted weekly for 1 month then monthly thereafter. The interviews shall also be conducted in private and documentation of the interviews shall be kept for 1 month. [REDACTED] 7/1/25) to assess abuse. Interviews initiated 6/19/2025. Staff persons B and E had left the facility prior to the abuse claim. Staff persons C and D were educated individually regarding proper care and respect of the residents on 06/25/2025 by administrator. Staff persons C and D were supervised by the administrator to monitor their interaction with residents on 06/23/2025 Both were instructed to call administrator immediately if any claims of abuse reported. Quality management meeting scheduled for 7/03/2025 addressing all items in 2600.26b. Minutes to be kept on file.

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/07/2025

Not Implemented [REDACTED] - 09/09/2025)**42e - Telephone Access****5. Requirements**

2600.

42.e. A resident shall have access to a telephone in the home to make calls in privacy. Nontoll calls shall be without charge to the resident.

Description of Violation

On numerous occasions, resident #2 was denied by numerous staff persons access to use the home's telephone to make telephone calls in private.

42e - Telephone Access (continued)

Plan of Correction

Directed [redacted] - 07/01/2025)

Resident 2 was calling 911 repeatedly and sending them to [redacted] home, per [redacted] request [redacted] was monitored so [redacted] wasn't calling 911. All staff were educated to permit [redacted] to use phone in private regardless of who [redacted] is calling. This education was completed on 06/27/25 at 1 PM by hospice staff development trainer. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 7/1/25). Administrator will interview resident 2 quarterly to ensure compliance. Interviews began on 6/19/2025. Quality management meeting scheduled for 7/03/2025 addressing all items in 2600.26b. Minutes to be kept on file.

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/03/2025

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

65a - FS Orientation 1st Day

6. 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.
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

Direct care staff person C, hired on [redacted]/24, did not receive orientation on any of topics specified in 2600.65a.

Direct care staff person D, hired on [redacted] 25, did not receive orientation on any of topics specified in 2600.65a.

Plan of Correction

Directed [redacted] - 07/01/2025)

Staff person C and D were retrained on 05/31/25 on all topics in 2600.65 by manager. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 7/1/25). All staff files were audited by administrator to ensure compliance. New hire checklist was added to new hire packet by administrator. (DIRECTED: The new hire checklist shall be implemented on 7/7/25 and used for all newly-hired staff persons to ensure timely completion of orientation in accordance with 2600.65a. The completed new hire checklists shall be kept in each staff person's record. [redacted] 7/1/25). Administrator will audit 2 staff files every quarter. Audits began on 06/17/2025. Quality management meeting scheduled for 7/03/2025 addressing all items in 2600.26b. Minutes to be kept on file.

Proposed Overall Completion Date: 06/30/2025

65a - FS Orientation 1st Day (continued)

Directed Completion Date: 07/07/2025

Implemented [redacted] - 09/09/2025)

65b - Rights/Abuse 40 Hours

7. 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

Direct care staff person C, hired on [redacted]/24, did not receive orientation on any of topics specified in 2600.65b.

Direct care staff person D, hired on [redacted]/25, did not receive orientation on any of the topics specified in 2600.65b.

Plan of Correction

Directed [redacted] - 07/01/2025)

Staff person C and D were retrained on 05/31/25 on all topics in 2600.65 by manager. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 7/1/25). All staff files were audited by administrator to ensure compliance. New hire checklist was added to new hire packet by administrator. (DIRECTED: The new hire checklist shall be implemented on 7/7/25 and used for all newly-hired staff persons to ensure timely completion of orientation in accordance with 2600.65b. The completed new hire checklists shall be kept in each staff person's record. [redacted] 7/1/25). Administrator will audit 2 staff files every quarter. Audits began on 06/17/2025. Quality management meeting scheduled for 7/03/2025 addressing all items in 2600.26b. Minutes to be kept on file.

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/07/2025

Implemented [redacted] - 09/09/2025)

65e - 12 Hours Annual Training

8. Requirements

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person A, hired on [redacted]/17, only received 7 hours of annual training during the 2024 training year.

Plan of Correction

Directed [redacted] - 07/01/2025)

Staff person A was retrained on the missing trainings by administrator on 5/31/2025, 06/02/2025, and 06/03/2025

65e - 12 Hours Annual Training (continued)

for a total of 6 hours. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 7/1/25). The administrator will review all direct care staff training records quarterly to ensure all direct care staff persons receive at least 12 hours of annual training each year in accordance with 2600.65e. (DIRECTED: The administrator quarterly reviews shall begin on 7/7/25 to ensure compliance with 2600.65e. [REDACTED] 7/1/25). All staff records were reviewed for compliance. Administrator will audit 2 staff files every quarter to ensure continued compliance. Audits initiated on 5/31/2025. Quality management meeting scheduled for 7/03/2025 addressing all items in 2600.26b. Minutes to be kept on file.

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/07/2025

Implemented [REDACTED] - 09/09/2025)

65f - Training Topics

9. 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.
3. Care for residents with dementia and cognitive impairments.
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 person A, hired on [REDACTED]/17, did not receive training on the following topics during the 2024 training year:

- Medication self-administration training
- Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan
- Care for residents with dementia and cognitive impairments
- Care for residents with mental illness or an intellectual disability. Currently, the home serves numerous residents with mental illnesses and intellectual disabilities.

Plan of Correction

Directed [REDACTED] - 07/01/2025)

Staff person A was retrained on the missing trainings by administrator on 5/31/2025, 06/02/2025, and 06/03/2025 for a total of 6 hours. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 7/1/25). The administrator will review all direct care staff training records quarterly to ensure all direct care staff persons receive at least 12 hours of annual training each year in accordance with 2600.65e. (DIRECTED: Beginning on 7/7/25: The administrator shall audit all training records at least quarterly to ensure all direct care staff persons receive training on all topics specified in 2600.65f during each training year. [REDACTED] 7/1/25).

All staff records were reviewed for compliance. Administrator will Audits initiated on 5/31/2025. Quality management meeting scheduled for 7/03/2025 addressing all items in 2600.26b. Minutes to be kept on file.

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/07/2025

65f - Training Topics (continued)

Implemented [REDACTED] - 09/09/2025)

65g - Annual Training Content

10. 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:

- 2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
- 4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Description of Violation

Direct care staff person A. hired on [REDACTED]/17, did not receive training on the following topics during the 2024 training year:

- Emergency preparedness procedures and recognition and response to crises and emergency situations
- The Older Adult Protective Services Act (OAPSA)

Plan of Correction

Directed [REDACTED] - 07/01/2025)

Staff person A was retrained on Emergency preparedness and Older adult protective services act on 05/31/2025 by the administrator (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 7/1/25). The administrator will review all direct care staff training records quarterly to ensure all direct care staff persons receive at least 12 hours of annual training each year in accordance with 2600.65e. (DIRECTED: Beginning on 7/7/25: The administrator shall audit all training records at least quarterly to ensure all direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers receive training on all topics specified in 2600.65g during each training year. [REDACTED] 7/1/25). All staff records were reviewed for compliance. . Audits initiated on 5/31/2025. Quality management meeting scheduled for 7/03/2025 addressing all items in 2600.26b. Minutes to be kept on file.

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/07/2025

Implemented [REDACTED] - 09/09/2025)

65i - Training Record

11. Requirements

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The following records of training for direct care staff person A, hired on [REDACTED]/17, did not include the length of the training:

- Personal hygiene training, conducted on 1/12/24
- Resident rights training, conducted on 2/12/24
- Infection control training, conducted on 3/16/24

65i - Training Record (continued)

- Falls and falls prevention, conducted on 4/22/24

REPEAT VIOLATION: 10/30/2024

Plan of Correction

Directed [REDACTED] - 07/01/2025)

Staff person A was retrained on the missing trainings by administrator for a total of 6 hours. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 7/1/25). The administrator will review all direct care staff training records quarterly to ensure all direct care staff persons receive at least 12 hours of annual training each year in accordance with 2600.65e. (DIRECTED: Beginning on 7/7/25: The administrator shall audit all training records at least quarterly to ensure all items specified in 2600.65i are present on all training documentation. [REDACTED] 7/1/25). Audits initiated on 5/31/2025. All staff records were reviewed for compliance. Administrator will audit 2 staff files every quarter to ensure continued compliance. Quality management meeting scheduled for 7/03/2025 addressing all items in 2600.26b. Minutes to be kept on file.

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/07/2025

Not Implemented [REDACTED] - 09/09/2025)

100a - Exterior - Free of Hazards

12. Requirements

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

At 9:20 AM, the landing at the top of the 2nd floor external wooden fire escape was covered with a piece of plywood, posing a tripping hazard to the residents. Per staff person F, the home's administrator, the plywood was placed there because the wooden deck boards underneath are "soft" and in need of replacement.

REPEAT VIOLATION: 3/12/2025

Plan of Correction

Directed [REDACTED] - 07/01/2025)

The wooden deck boards were replaced on 6/24/25 by owner. Owner walked the around the exterior of the building and the building grounds/yard ensuring things are in good repair. Owner will inspect the exterior of the home weekly for 2 months then monthly thereafter to ensure compliance with 2600.100a. (DIRECTED: The monitoring of the home's exterior to ensure compliance with 2600.100a shall begin on 7/7/25). Quality management meeting scheduled for 7/03/2025 addressing all items in 2600.26b. Minutes to be kept on file

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/07/2025

Implemented [REDACTED] - 09/09/2025)

225a - Assessment 15 Days

13. 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 #2's medical evaluation, dated [REDACTED]/24, includes diagnoses of Pain, Depression, Schizophrenia and Allergies; however, these diagnoses are not indicated on resident #2's assessment, dated [REDACTED] 9/24.

Plan of Correction**Accept [REDACTED] - 07/01/2025)**

All diagnoses were added to resident #2s assessment on [REDACTED]/2025 by administrator. All resident files were audited and updated where required by administrator on 6/24/2025. Audits began on 6/24/2025. Administrator will audit 3 records every quarter to ensure compliance. Quality management meeting scheduled for 7/03/2025 addressing all items in 2600.26b. Minutes to be kept on file.

Proposed Overall Completion Date: 06/30/2025

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

Implemented [REDACTED] - 09/09/2025)

225c - Additional Assessment

14. Requirements

2600.

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

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

Description of Violation

Resident #5's most recent medical evaluation, dated [REDACTED]/24, includes diagnoses of Allergies, Depression and Epilepsy; however, these diagnoses are not indicated on resident #5's most recent assessment, dated [REDACTED] 24.

Resident #7's most recent medical evaluation, dated [REDACTED]/25, includes diagnoses of Arthritis, Acid Reflux, and Anxiety; however, these diagnoses are not indicated on resident #7's most recent assessment, dated [REDACTED]/25.

Plan of Correction**Directed ([REDACTED] - 07/01/2025)**

All diagnoses were added to resident # 5 and #7s assessment by administrator on 06/24/2025. All resident files were audited and updated where required by administrator on 06/24/2025. Administrator will audit 3 records quarter to ensure compliance. Audits began on 06/24/2025. Quality management meeting scheduled for 7/03/2025

225c - Additional Assessment (continued)

addressing all items in 2600.26b. Minutes to be kept on file.

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/03/2025

Implemented [REDACTED] - 09/09/2025)

227g -Support Plan Signatures**15. Requirements**

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #2's support plan, dated [REDACTED]/24, is not signed by the resident and does not indicate if resident #2 was unable to participate, declined to participate, refused to sign or was unable to sign.

Plan of Correction

Accept [REDACTED] - 07/01/2025)

Resident 2's support plan was signed but there was a typo on the date and was dated [REDACTED]/23 the support plan date was corrected by administrator, reviewed and signed by resident 2 on 6/24/2025 All resident files were audited for signatures and correct dates by manager on 06/24/2025. Administrator will audit 3 records per quarter to ensure compliance. Audits began on 06/24/2025. Quality management meeting scheduled for 7/03/2025 addressing all items in 2600.26b. Minutes to be kept on file.

Proposed Overall Completion Date: 06/30/2025

Licensee's Proposed Overall Completion Date: 07/03/2025

Implemented [REDACTED] 09/09/2025)

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

Facility Information

Name: *LASOSKY'S PERSONAL CARE HOME, INC.* License #: *41858* License Expiration: *02/22/2026*
Address: *23 MAIN STREET, PO BOX 27, CLARKSVILLE, PA 15322*
County: *WASHINGTON* Region: *WESTERN*

Administrator

Name: [REDACTED]

Legal Entity

Name: *LASOSKYS PERSONAL CARE HOME INC*
Address: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *07/02/1998* Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: Total Daily Staff: *22* Waking Staff: *17*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Monitoring* Exit Conference Date: *08/01/2025*

Inspection Dates and Department Representative

07/28/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *25* Residents Served: *21*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *4* Are 60 Years of Age or Older: *18*
Diagnosed with Mental Illness: *9* Diagnosed with Intellectual Disability: *2*
Have Mobility Need: *1* Have Physical Disability: *0*

Inspections / Reviews

07/28/2025 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *08/21/2025*

Inspections / Reviews (*continued*)

08/27/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: 09/04/2025
Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 09/02/2025

09/02/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: 09/04/2025
Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 09/05/2025

09/09/2025 - Document Submission

Submitted By: [REDACTED] Date Submitted: 09/04/2025
Reviewer: [REDACTED] Follow-Up Type: Enforcement

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

Resident #1 ceased to breathe in the home on resident #1's date of death; however, resident #1's death was not reported to the Department.

Plan of Correction

Accept [redacted] - 09/02/2025)

The death was reported via fax by the manager. Department states that they did not receive it. Incident report was resent on 9/1/2025 via email.

All deaths will now be reported via email thus leaving documentation of the report. Email given to manager who will be responsible in sending incident reports in the administrators absence. Training on reportable incidents performed by administrator given to manager on 8/28/2025, documentation shall be kept.

Administrator immediately began reviewing and will continue reviewing all reportable incidents daily with manager or supervisor and will ensure email was sent. As previously stated above, administrator is reviewing all internal incidents daily to ensure all reportable incidents specified in 2600.16a are reported to the Department within 24 hours.

Licensee's Proposed Overall Completion Date: 09/01/2025

Not Implemented [redacted] - 09/09/2025)

60a - Staff/Support Plan

2. 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

On numerous occasions, to include the following dates/times, no staff person was present in the home who is qualified to administer medications. There are numerous residents in the home who are unable to self-administer medications and are prescribed pro re nata (PRN) medications:

- *On 7/30/25 from approximately 10:00pm through 6:00am on 7/31/25*
- *On 7/20/25 from approximately 10:00pm through 6:00am on 7/21/25*
- *On 7/9/25 from approximately 10:00pm through 6:00am on 7/10/25*
- *On 7/7/25 from approximately 10:00pm through 6:00am on 7/8/25*

Plan of Correction

Accept [redacted] - 09/02/2025)

There are not routine medications prescribed to residents on this shift. There is a staff person working "on call" who can be at the facility in less than 5 minutes who administers as needed medications which has passed in previous inspections.

60a - Staff/Support Plan (continued)

As of August there is and will continue be a med tech on all shifts. Manager was educated regarding need for med tech on on all shifts. Schedule will be marked MT to identify the person assigned. Manager will submit the schedule to administrator upon completion every two weeks who will ensure there is a med tech assigned.

No additional training was required to meet the overnight med tech needs, instead overtime was utilized, and previously trained med techs were scheduled.

The home will initiate a tracking system which includes all med tech training dates and dates of their practicum observations by a train-the-trainer (the homes administrator). Tracking will begin on 9/3/2025 and the administrator will review the tracking system quarterly to ensure all med techs receive their annual practicums throughout the year in accordance with the Department-approved medication administration program. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: 09/03/2025

Implemented [REDACTED] - 09/09/2025)