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

September 9, 2025

DUBOIS CONTINUUM OF CARE COMMUNITY INC

RE: DUBOIS VILLAGE
282 SOUTH EIGHTH STREET
DUBOIS, PA, 15801
LICENSE/COC#: 44867

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/06/2025 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *DUBOIS VILLAGE* **License #**: *44867* **License Expiration**: *06/04/2026*

Address: *282 SOUTH EIGHTH STREET, DUBOIS, PA 15801*

County: *CLEARFIELD* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *DUBOIS CONTINUUM OF CARE COMMUNITY INC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *79* **Waking Staff**: *59*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *08/06/2025*

Inspection Dates and Department Representative

08/06/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *118* **Residents Served**: *62*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Willow Lane* **Capacity**: *9* **Residents Served**: *6*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *2* **Are 60 Years of Age or Older**: *62*
Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *2*
Have Mobility Need: *17* **Have Physical Disability**: *0*

Inspections / Reviews

08/06/2025 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/26/2025*

08/25/2025 - POC Submission

Submitted By: **Date Submitted**: *09/04/2025*

Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/12/2025*

Inspections / Reviews *(continued)*

09/09/2025 Document Submission

Submitted By: [redacted]
Date Submitted: *09/04/2025*
Reviewer: [redacted]
Follow Up Type: *Not Required*

42c - Treatment of Residents

1. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On at approximately 7:30 p.m., direct care staff A was providing continence care to resident in the resident's bedroom. According to staff interviews, resident was agitated, and not complying with staff prompts to go to the bathroom and attempted to sit down in a recliner. Direct care staff A became frustrated, raised the volume of voice and using a stern tone of voice directed the resident to not sit down and come to the bathroom, while physically hooking arm under the resident's arm, preventing the resident from sitting and directing them to the bathroom. This upset resident caused to cry and said "Why are you being so mean?"

Plan of Correction ***Accept - 08/25/2025)***

1. Resident Care Manager notified via a phone call on 7-26-25 approximately 10:30 am by resident's about incident that family witnessed on a non-recorded video on security camera 7-25-25 after supper. Direct care staff A was immediately put on an administrative leave of absence by Administrator, pending investigations.
2. Resident was interviewed by RCM and no recollection of the previous evening noted.
3. Act 13 Mandatory report sent to Clearfield County AAA Adult Protective Services after verbal report given by RCM. Reportable Incident sent to The Department of Human Services by RCM.
4. Local APS did not substantiate this incident as abuse when finished with their investigation on 7-31-25.
5. Direct Care Staff A remained on administrative leave from 7-26-25 to 8-8-25. received a disciplinary action with a three (3) day unpaid suspension by Administrator on 8-6-25.
6. Direct Care Staff A was required to attend training on Adult Protective Services Mandatory Reporting and definitions of abuse. Dementia Training, Resident Rights, Safe Management Techniques and the Prohibition of Restraint Use prior to returning to duty. Trainings administered by Administrator on 8-8-25.
7. Mandatory Education to all staff on APS by Administrator beginning 7-28-25 through 8-25-25. Mandatory education to all staff on Resident Rights, Safe Management Techniques and Prohibition of Restraints use beginning 8-13-25 through 8-25-25 by Administrator.
8. Beginning 8-7-25 Administrator or Designated Person will perform Resident Rights/Restraint random daily audit for 5 residents and staff interactions x 2 weeks, then Resident Rights/Restraint random weekly audit for 5 residents and staff interactions x 1 month, then Resident Rights/Restraint random monthly audit for 5 residents and staff interactions ongoing.
9. Audits will be reviewed for compliance at monthly QA meeting.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented - 09/09/2025)

202 - Prohibitions

2. Requirements

2600.
202. The following procedures are prohibited:

Description of Violation

On at approximately 7:30 p.m., direct care staff A was providing continence care to resident in the resident's bedroom. According to staff interviews, resident was agitated, and not complying with staff prompts to go to the bathroom and attempted to sit down in a recliner. Direct care staff A became frustrated, raised the volume of

202 - Prohibitions (continued)

voice and using a stern tone of voice directed the resident to not sit down and come to the bathroom, while physically hooking arm under the resident's arm, preventing the resident from sitting and directing them to the bathroom. This upset resident , caused to cry and said "Why are you being so mean?"

Plan of Correction ***Accept - 08/25/2025)***

1. Resident Care Manager notified via a phone call on 7-26-25 approximately 10:30 am by resident's about incident that family witnessed on a non-recorded video on security camera 7-25-25 after supper. Direct care staff A was immediately put on an administrative leave of absence by Administrator, pending investigations.
2. Resident was interviewed by RCM and no recollection of the previous evening noted.
3. Act 13 Mandatory report sent to Clearfield County AAA Adult Protective Services after verbal report given by RCM. Reportable Incident sent to The Department of Human Services by RCM.
4. Local APS did not substantiate this incident as abuse when finished with their investigation on 7-31-25.
5. Direct Care Staff A remained on administrative leave from 7-26-25 to 8-8-25. received a disciplinary action with a three (3) day unpaid suspension by Administrator on 8-6-25.
6. Direct Care Staff A was required to attend training on Adult Protective Services Mandatory Reporting and definitions of abuse. Dementia Training, Resident Rights, Safe Management Techniques and the Prohibition of Restraint Use prior to returning to duty. Trainings administered by Administrator on 8-8-25.
7. Mandatory Education to all staff on APS by Administrator beginning 7-28-25 through 8-25-25. Mandatory education to all staff on Resident Rights, Safe Management Techniques and Prohibition of Restraints use beginning 8-13-25 through 8-25-25 by Administrator.
8. Beginning 8-7-25 Administrator or Designated Person will perform Resident Rights/Restraint random daily audit for 5 residents and staff interactions x 2 weeks, then Resident Rights/Restraint random weekly audit for 5 residents and staff interactions x 1 month, then Resident Rights/Restraint random monthly audit for 5 residents and staff interactions ongoing.
9. Audits will be reviewed for compliance at monthly QA meeting.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented (- 09/09/2025)