pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ALWAYS ON CARE LLC**
LEGAL ENTITY

To operate **ALWAYS ON CARE**
NAME OF FACILITY OR AGENCY

Located at **600 NORTH LAUREL STREET, HAZELTON, PA 18201**
(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 **26**
(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 **November 21, 2025** until **May 21, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **230062**

ISSUING OFFICER

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.

HS 628P – 04/23

Pennsylvania
Department of Human Services

Sent via email to: [redacted]
CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: NOVEMBER 21, 2025

[redacted]
Always On Care LLC
[redacted]

RE: Always On Care
600 North Laurel Street,
Hazelton, Pennsylvania, 18201
License: 230062

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on August 28, 2025, September 4, 2025, September 24, 2025, and October 16, 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 issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND 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); (5); (6) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from NOVEMBER 21, 2025 TO MAY 21, 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.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 or § 2800 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 or 2800 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
57a	II	22	$5	$110	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

If you disagree with the decision to issue a 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, Pennsylvania 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

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: *ALWAYS ON CARE* **License #:** *23006* **License Expiration:** *08/18/2025*

Address: *600 NORTH LAUREL STREET, HAZELTON, PA 18201*

County: *LUZERNE* **Region:** *NORTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *ALWAYS ON CARE LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date:** *04/22/2010* **Issued By:** *Dept L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *20* **Waking Staff:** *15*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date:** *10/03/2025*

Inspection Dates and Department Representative

09/04/2025 - On-Site: [redacted]
09/24/2025 - On-Site:
10/03/2025 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *26* **Residents Served:** *18*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *14* **Are 60 Years of Age or Older:** *14*

Diagnosed with Mental Illness: *14* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *2* **Have Physical Disability:** *3*

Inspections / Reviews

09/04/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/11/2025*

10/31/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/31/2025*

Reviewer: [redacted] **Follow-Up Type**: *Bypass Document Submission*

11/10/2025 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted**: *10/31/2025*

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

On [redacted]/25, Resident #3 left the facility between lunch and dinner. The resident was found at the Emergency Department of the local hospital at approximately 6:00 p.m. The resident's assessment dated [redacted]/25 indicates the resident has short term memory deficits, is not oriented to person, place, or time and is unaware of safety of self or others. As of 9/26/25 the home did not report this incident to the department.

On 7/12/25, the fire alarm monitoring companies activity log indicates at 4:16 p.m. FIRE-SMOKE DETECTED. At 4:18 p.m. the fire department was dispatched. As of 10/3/25 the home did not report the fire department responding to the home to the Department.

Plan of Correction ***Directed [redacted] - 10/27/2025)***

The Administrator will review all incident reports weekly to confirm that any event requiring DHS notification has been reported within 24 hours and that documentation is complete.
Beginning October 20, 2025, the Administrator will implement a Revised Incident Reporting Procedure that includes the following steps:
1. Immediate Documentation: All staff must complete an Internal Incident Report form within 1 hour of any incident or unusual event.
2. Administrator Notification: The on-call or onsite Administrator must be notified immediately of all incidents that could impact resident safety or facility operations.
3. Regulatory Reporting: The Administrator will ensure that any incident meeting §2600.16(c) criteria is reported to DHS within 24 hours using the designated reporting method (email, fax, or hotline), with confirmation of receipt documented.
4. Training: By October 20, 2025, all staff and supervisors received retraining on Incident Identification and Reporting Requirements, including DHS timelines and examples of reportable events (e.g., elopement, injury, fire response, hospitalization).

Proposed Overall Completion Date: 10/30/2025

(Directed)
In addition to the above noted plan: The Administrator will implement a documentation system for direct care staff to document any concerning behaviors or incidents, during each shift. The Administrator will review this documentation daily for 3 months and initial the documentation after review. Reportable Incidents and Conditions will be reported to the Department as required. The Administrator or designee will file all completed and reported incident reports in a binder. This binder will be kept and available for review by the Department.

Directed Completion Date: *11/20/2025*

23a - Activities of Daily Living Assistance

2. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, dated [redacted]/25, for Resident #3 indicates the resident requires assistance with supervision in unfamiliar areas. On [redacted]/25 between lunch and dinner, Resident #3 went outside to purchase ice cream and made staff aware prior to leaving the building. Resident #3 went missing for at least 2 hours before the home became aware of the resident's hospital admission. An interview with Resident #3 indicated that the resident became confused, got lost outside, and was admitted into the hospital. The home did not provide the assistance needed to Resident #3 as identified in the assessment and support plan.

Plan of Correction ***Directed [redacted] - 10/27/2025)***

On October 13, 2025, the Administrator immediately reviewed the incident involving Resident #3 and provided re-education to all staff on the supervision requirements outlined in each resident's assessment and support plan. The Resident Care Coordinator updated Resident #3's support plan on the same date to clearly indicate that the resident must be accompanied by staff when outside the home or leaving facility grounds, regardless of prior notice to staff.

Beginning October 20, 2025, the Administrator will ensure that:

Assessment Review and Alignment: The Resident Care Coordinator will review all residents' assessments and support plans to verify that supervision requirements are clearly defined and individualized. Any resident requiring assistance in unfamiliar or community settings will have this documented in bold print on their plan.

Staff Training: All direct care staff will receive quarterly training on the supervision of residents as indicated in assessments and support plans, including procedures for community outings, elopement prevention, and staff-to-resident accountability while off-site.

The Administrator will review supervision logs and resident sign-out records monthly to confirm compliance with support plan directives.

Proposed Overall Completion Date: 10/30/2025

(Directed)
In addition to the above noted plan: The Administrator and lead care staff will review the activities of daily living needs (ADL's) including hygiene, toileting and supervision needs of each current resident and the resident's assessment and support plans (RASP). All RASP's will be updated to reflect the needs of each resident. The administrator or designee will conduct a training for all staff that will include ADL's and the RASP. Documentation will be maintained for the Department to review upon request.

Directed Completion Date: *11/20/2025*

57a - Designee Present/Age

3. Requirements

57a - Designee Present/Age *(continued)*

2600.
57.a. At all times one or more residents are present in the home a direct care staff person who is 21 years of age or older and who serves as the designee, shall be present in the home. The direct care staff person may be the administrator if the administrator provides direct care services.

Description of Violation

On 8/15/25 and 8/17/25 from 6:30 a.m. to 7:30 p.m., 22 residents were present in the home. During this time, Staff Person A was the only person scheduled to work. An interview with Staff Person A concluded they were not at work during these time periods. The home could not provide timecards to verify who worked during this time period.

On 8/17/25 from 7:30 p.m. to 10:00 p.m. 22 residents were present in the home. Staff Person A was the only person scheduled to work. An interview with Staff Person A concluded they were not at work during these time periods. The home could not provide timecards to verify who worked during this time period.

Repeat violation: 11/27/24 et al

Plan of Correction ***Accept ([redacted] - 10/27/2025)***

On October 13, 2025, the Administrator immediately conducted a full review of all staffing schedules, timecards, and attendance logs for August 2025 to confirm gaps and verify actual coverage. A corrective memo was issued to all scheduling and direct care personnel, requiring daily verification of on-duty staff presence using the time-clock and supervisor cross-check system.

On the same date, the Administrator provided written notice to all staff reinforcing that a qualified designee (21 years or older) must be physically present whenever residents are in the home. Any shift found without appropriate coverage will now result in disciplinary action and immediate notification to the Administrator.

A qualified staff person (age verified and trained) was designated and documented as Designee-on-Duty for every shift beginning October 14, 2025.

The Administrator will review the staff attendance records weekly for accuracy and completeness.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] - 10/31/2025)

57c - 2 Hours/Day

4. Requirements

2600.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On 8/15/25, there were 22 residents in the home, including 2 residents with mobility needs. The home is required to have 24 hours of direct care staffing hours. On this date, only 15.5 hours of direct care staffing were available.

57c - 2 Hours/Day (continued)

On 8/16/25, there were 22 residents in the home, including 2 residents with mobility needs. The home is required to have 24 hours of direct care staffing hours. On this date, only 20 hours of direct care staffing were available.

On 8/17/25, there were 22 residents in the home, including 2 residents with mobility needs. The home is required to have 24 hours of direct care staffing hours. On this date only 8 hours of direct care staffing were available.

Plan of Correction ***Accept [redacted] - 10/27/2025)***

On October 13, 2025, the Administrator reviewed the August staffing schedules, payroll records, and daily census logs to identify the specific dates and hours where staffing fell below minimum requirements. Staffing shortages were confirmed for August 15–17, 2025.
Beginning October 20, 2025, the Administrator will maintain full compliance with §2600.57(c) through the following measures:

Staffing Schedule Review:
The Administrator will prepare staffing schedules two weeks in advance, ensuring that each day includes at least 24 total hours of direct care staffing coverage to meet personal care service needs for all residents with mobility support requirements.
The Administrator immediately adjusted the current staffing schedule to ensure that at least two direct care staff members are on duty at all times and that all residents with mobility needs receive no less than two hours of direct personal care service daily.
The Administrator will monitor compliance through the following actions:

Weekly Review: Review the Daily Staffing Verification Logs each Friday to confirm that required staffing hours were met for every day that week.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] - 10/31/2025)

57d - Waking Hours

5. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 8/15/25, 18 hours of direct care staffing hours was required during waking hours (7:00 a.m. to 11:00 p.m.). Only 3.5 hours of direct care staffing was available.

On 8/16/25, 18 hours of direct care staffing was required during waking hours (7:00 a.m. to 11:00 p.m.). Only 16 hours of direct care staffing was available.

On 8/17/25, 18 hours of direct care staffing was required during waking hours (7:00 a.m. to 11:00 p.m.). Zero hours of direct care staffing was available.

57d - Waking Hours (continued)

Plan of Correction ***Accept [redacted] - 10/27/2025)***

On October 13, 2025, the Administrator reviewed the August 2025 staffing schedules and payroll records to verify the cited deficiencies. It was confirmed that coverage did not meet the minimum waking-hour staffing requirements on the above dates.

To immediately correct the issue, the Administrator adjusted the current staffing pattern to ensure that at least 75% of required personal care service hours occur during waking hours (7:00 a.m.–11:00 p.m.). A Waking-Hours Coverage Schedule was implemented on October 14, 2025, guaranteeing two or more direct care staff are on duty during all waking periods to meet residents' needs.

Beginning October 20, 2025, the following permanent procedures will be implemented to prevent recurrence:

Advance Scheduling and Review:
The Direct Care Supervisor will prepare staffing schedules two weeks in advance. The Administrator will review and sign off weekly to verify that at least 75% of staffing hours are assigned to waking periods.

The Administrator will review the Daily Staffing Log each Friday to verify compliance with the 75% waking-hour requirement.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] - 10/31/2025)

65d - Initial Direct Care Training

6. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
3. Initial direct care staff person training to include the following:
xi. Care and needs of residents with special emphasis on the residents being served in the home.

Description of Violation

The initial direct care staff training for Staff persons A and B does not include training for the care needs of residents diagnosed with a traumatic brain injury. On [redacted]25, the home admitted Resident #2 who has a diagnosis of traumatic brain injury.

Plan of Correction ***Accept [redacted] - 10/27/2025)***

On October 13, 2025, the Administrator immediately reviewed all current staff training records and identified staff members who lacked TBI-specific training. Staff Persons A and B were removed from unsupervised duties with Resident #2 until they completed supplemental training. By October 14, 2025, both staff will complete a documented Traumatic Brain Injury Care and Support Training, which includes the care needs, behavioral supports, and communication strategies specific to individuals with TBI. The Administrator will verify completion and update the

65d - Initial Direct Care Training (continued)

training records on the same date.
Beginning October 20, 2025, the Administrator will ensure that all new direct care staff receive resident-specific care training during their initial orientation, including any specialized care needs (such as TBI, dementia, or behavioral health). The Administrator will update the Initial Direct Care Staff Training Curriculum to include a mandatory section titled "Care Needs of Residents with Specialized Diagnoses" to be completed before any staff provides unsupervised care.
All supervisory staff will be retrained by October 30, 2025, regarding their responsibility to confirm completion of specialized training prior to assigning staff to unsupervised ADL duties.
The Administrator will review staff training files by 10/30/25 to verify that each direct care staff person's training includes all components required under §2600.65(d)(3), with emphasis on specialized diagnoses present in the home.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] - 10/31/2025)

85a - Sanitary Conditions

7. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 9/4/25 at 9:15 a.m., the second floor hallway had a strong odor of urine coming from the men's bathroom.

Plan of Correction ***Accept ([redacted] - 10/27/2025)***

On October 10, 2025, the Administrator inspected the second-floor men's bathroom and identified that the odor originated from residual urine around the toilet base and flooring. The administrator told the auxiliary staff to perform a deep cleaning and disinfecting of the entire bathroom area, including flooring, baseboards, fixtures, and drains.
A maintenance inspection was conducted on the same date to verify the integrity of the flooring and plumbing seals.
Beginning October 20, 2025, the administrator will implement the following ongoing sanitation procedures to prevent reoccurrence:
1. Scheduled Cleaning Protocol:
All resident bathrooms and adjoining hallways will be cleaned and disinfected twice daily and checked every 3 hours during waking hours for odors, spills, or maintenance issues.
The Administrator will monitor ongoing compliance by conducting random weekly environmental rounds on each floor.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] - 10/31/2025)

130f - Testing Smoke Detectors

8. Requirements

2600.

130f - Testing Smoke Detectors *(continued)*

130.f. Smoke detectors and fire alarms shall be tested for operability at least once per month. A written record of the monthly testing shall be kept.

Description of Violation

The home's smoke detectors and fire alarms were not tested for the last 12 months.

Plan of Correction ***Directed [redacted] - 10/27/2025)***

On September 30, 2025, the Administrator contacted the licensed fire alarm monitoring and maintenance company to perform a fire drill. The testing was completed on that date, and a written verification report was received and filed in the Fire Safety Binder for Department review.

The Administrator also verified that the alarm system is functioning properly and that the alarm system was connected and actively monitored.

The Administrator will review the Monthly Smoke Detector and Fire Alarm Testing Log at the end of each month to verify that all devices were tested and that records are complete.

Proposed Overall Completion Date: 10/30/2025

(Directed)
Effective immediately all smoke detectors and fire alarms will be tested during the monthly drill. Documentation of the operability will be documented with the monthly fire drill documentation with the initials of the person responsible for conducting the fire drill.

Directed Completion Date: *11/20/2025*

132a - Monthly Fire Drill

9. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The fire drill conducted on 9/22/25 at 11:17 a.m. was announced to Staff persons A and B by Staff person C who conducts the fire drills, 5 minutes prior to conducting the fire drill.

Plan of Correction ***Directed [redacted] - 10/27/2025)***

By October 17, 2025, the Administrator will meet with Staff Person C and all supervisory staff to review and clarify the DHS requirement that all fire drills must be unannounced to staff and residents.

By October, 30 an unannounced fire drill will e conducted by the Administrator to ensure compliance with §2600.132(a). The Administrator will review the Fire Drill Compliance Log monthly to ensure drills remain unannounced and properly documented.

Proposed Overall Completion Date: 10/30/2025

(Directed)
Effective immediately only the staff responsible for setting off the alarm or detector and recording the results will be aware that a drill will occur. The Administrator will train all staff regarding the requirement that an unannounced fire drill shall be conducted at least once a month. Documentation will be

132a - Monthly Fire Drill (continued)

maintained for the Department to review upon request.

Directed Completion Date: *11/20/2025*

132i - Testing Fire Alarm

10. Requirements

2600.
132.i. A fire alarm or smoke detector shall be set off during each fire drill.

Description of Violation

Staff interviews indicated that during fire drills, the fire alarm is not sounded. In its place, Staff person C uses their cellular phone to simulate an alarm sound.

Plan of Correction ***Directed (RY - 10/27/2025)***

On September 30, 2025, the Administrator met with Staff Person C and all supervisory staff to review the regulation requiring that the facility's actual fire alarm system or smoke detector must be set off during every fire drill. The Administrator immediately directed that cell phone or manual sound substitutions are prohibited.

On October 14, 2025, the Administrator personally conducted an unannounced fire drill using the building's operational fire alarm panel. All staff and residents participated, and the drill was documented and filed in the Fire Safety Binder to demonstrate full system use and compliance.

The Administrator will review the Fire Drill Verification Log after each monthly drill to confirm that the building's alarm system was properly used and documented.

Proposed Overall Completion Date: 10/30/2025

(Directed)
Effective immediately the fire alarms will be activated during each monthly fire drill. The Administrator and any staff involved in conducting fire drills will have training that includes a review of the fire drill regulations and additional information regarding Fire Drills and Evacuation within the Regulatory Compliance Guide for the Chapter 2600 regulations.

Directed Completion Date: *11/20/2025*

187b - Date/Time of Medication Admin.

12. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

An interview with Staff person B indicated that when completing a morning medication pass, the staff person administers the medications to all the residents and initials the medication as administered on the medication administration record 1 to 1.5 hours after administering the medication. Repeat Violation: 10/22/24

Plan of Correction ***Directed ([redacted] - 10/27/2025)***

On October 13, 2025, the Administrator met with Staff Person B to clarify documentation procedures. It was determined that the delay in recording occurred only after breakfast service, not during the medication pass. Because Staff Person B begins the medication round at 7:00 a.m. while also assisting with breakfast, some MARs were

187b - Date/Time of Medication Admin. (continued)

signed immediately following the meal rather than at the exact moment of administration.

The Administrator will observ a complete medication pass by October 30, 2025, and verify that all medications are administered correctly and that entries are recorded immediately at the time of administration.

On the same date, all medication-certified staff received a refresher training covering:

The DHS requirement to record medication administration in real time,

Proper MAR documentation technique, and

Managing dual responsibilities (meal service and med pass) without delaying recordkeeping.

Training attendance was documented in the Staff Development Log.

The Administrator will review medication-pass observation logs weekly and audit MARs monthly to confirm documentation accuracy.

Proposed Overall Completion Date: 10/30/2025

(Directed)
In addition to the above noted plan: The Administrator will conduct weekly observations of medication administration. These observations will occur on different days, times and shifts for 3 months. Any problems noted will be corrected immediately. The observations will be documented and maintained for the Department to review upon request.

Directed Completion Date: *11/20/2025*

223a - Description of Service

13. Requirements

2600.
223.a. The home shall have a current written description of services and activities that the home provides including the following:
1. The scope and general description of the services and activities that the home provides.
2. The criteria for admission and discharge.
3. Specific services that the home does not provide, but will arrange or coordinate.

Description of Violation

The home's current written description of services and activities that the home provides does not include services for a resident requiring monitoring every 15 minutes, or residents with a diagnosis of a traumatic brain injury. Resident #2 requires this 15 minute monitoring and has a diagnosis of a traumatic brain injury.

Plan of Correction ***Accept [redacted] - 10/27/2025)***

On October 13, 2025, the Administrator immediately reviewed and revised the facility's Written Description of Services and Activities to include language describing support for:

223a - Description of Service (continued)

Residents who require increased observation or monitoring (including 15-minute checks).

Residents with specialized care needs such as Traumatic Brain Injury (TBI) or other neurological conditions.

The revised description now clearly states that "Always On Care provides supervision and support for residents requiring individualized monitoring intervals and specialized care coordination for residents diagnosed with conditions such as traumatic brain injury. Services include staff training, behavioral monitoring, safety planning, and coordination with medical and rehabilitation providers as needed."

Staff will be retrained by October 30, 2025 to ensure understanding of the revised description and criteria for accepting residents with specialized needs. Documentation of this retraining is filed in the staff development log.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] - 10/31/2025)

227c - Support Plan Revision

14. 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

The assessment for resident #3, dated [redacted] /25, indicates the resident has a need for supervision in unfamiliar areas. The residents' support plan dated [redacted] /25 does not address how the home will meet this need.

Plan of Correction ***Directed [redacted] - 10/30/2025)***

On October 13, 2025, the Administrator reviewed Resident #3's assessment and support plan and immediately updated the plan to specify how supervision will be provided in unfamiliar areas. The revised plan now states that Resident #3 must be accompanied by staff whenever outside the facility or in any unfamiliar environment to ensure safety and orientation.
To prevent future occurrences and ensure all support plans accurately reflect each resident's current needs, the following measures are being implemented effective October 20, 2025:
Assessment–Support Plan Cross-Check:
The Resident Care Coordinator will compare every assessment to the corresponding support plan within five business days of completion to ensure all needs and supports align (e.g., mobility, supervision, ADL assistance).
30-Day Revision Rule Tracking:
A Support Plan Revision Log will be maintained to track all assessments and confirm that any changes in a resident's needs are addressed within 30 days. The Administrator will review and sign this log monthly.
The Administrator met with Resident #3 on October 13, 2025, to review and sign the updated plan.
The Administrator will review all new assessments and support plans monthly to ensure they are consistent and completed within regulatory timelines. The Resident Care Coordinator will maintain the Support Plan Revision Log

Proposed Overall Completion Date: 10/30/2025

(Directed)
In addition to the above noted plan: The Administrator will audit all current residents support plans to

227c - Support Plan Revision (continued)

ensure the residents needs are being met as identified in the assessment portion of the RASP. Documentation of the audit will be maintained for the Department to review upon request.

Proposed Overall Completion Date: 11/20/2025

Directed Completion Date: *11/20/2025*

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

Facility Information

Name: *ALWAYS ON CARE* **License #:** *23006* **License Expiration:** *08/18/2025*

Address: *600 NORTH LAUREL STREET, HAZELTON, PA 18201*

County: *LUZERNE* **Region:** *NORTHEAST*

Administrator

[redacted]

Legal Entity

Name: *ALWAYS ON CARE LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date:** *04/22/2010* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *23* **Waking Staff:** *17*

Inspection Information

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

Reason: *Incident* **Exit Conference Date:** *08/28/2025*

Inspection Dates and Department Representative

08/28/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *26* **Residents Served:** *23*

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:** *15*

Diagnosed with Mental Illness: *14* **Diagnosed with Intellectual Disability:** *0*

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

Inspections / Reviews

08/28/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/21/2025*

Inspections / Reviews *(continued)*

09/24/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/04/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/04/2025*

10/28/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/04/2025*

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

On [redacted]5 resident #3 reported that during the prior week resident #1 entered the shower room while resident #3 was showering. Resident #1 exposed themselves to resident #3 and made a sexually vulgar remark to resident #3. Also on [redacted]/25, resident #4 reported that approximately a few weeks prior, resident #1 approached resident #4, exposed themselves to resident #4 and grabbed resident #4's hand in an attempt to force resident #4 to touch their private area. Residents #3 and #4 stated that the home's administrator was made aware of the incidents when they occurred.
The home did not report the incidents to the Department's Regional office as required.

Plan of Correction ***Directed [redacted] - 09/24/2025)***

The violation stems from the administrator not being made aware of incidents involving residents 3 and 4. Immediate corrective action was taken by the administrator to fix the issue by educating the residents to report incidents to the administrator or staff of anything they are concerned of. The actions also included educating the staff on ensuring timely notification of incidents to the administrator that requires the Regional Department to be alerted within 24 hours of any reportable incident, and a report to the Department of Aging if warranted. This action also included a retrospective review of incidents from residents 3 and 4 and documenting findings in their RASP records.
Monitoring compliance will be led by the Administrator, with support from staff. The administrator will conduct monthly audits of incident reports, ensuring that any reportable incidents are escalated within 24 hours, and maintaining records in the facility's incident report folder.

Proposed Overall Completion Date: 10/01/2025

(DIRECTED)

All staff, including the administrator, will receive training in abuse reporting and prevention from an outside source. The home will train all staff on the home's internal reporting policy and who is responsible for reporting all resident incidents 24/7 including weekends. Training shall be completed by 10-04-2025. In the future, the administrator will ensure that all suspected abuse and incidents will be reported to the Department with in 24 hours of an incident.

Directed Completion Date: *10/04/2025*

Not Implemented [redacted] - 10/28/2025)

18 - Compliance With Laws

2. Requirements

18 - Compliance With Laws *(continued)*

2600.

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

Description of Violation

On [redacted]/25 at approximately 7:15 p.m. resident #1 cornered resident #2 near the elevator, pulled down their pants and asked resident #2 for a sex act. Resident #2 reported that resident #1 also attempted to grab their arm during the incident.

On [redacted]/25 at approximately 5:15 p.m. resident #1 approached resident #2 in the outdoor smoking area, pulled their pants down and again exposed themselves to resident #2. The incidents were not reported to [redacted] protective services until 8/28/25 when they were investigated by department licensing representatives.

Also, during the investigation on 8/28/25, two additional residents reported similar incidents that occurred in the weeks prior to the incidents on 8/26/25 and 8/27/25:

Resident #3 reported that approximately a week prior, resident #1 entered the shower room while resident #3 was showering. Resident #1 exposed themselves to resident #3 and made a sexually vulgar remark to resident #3.

Resident #4 reported that approximately a few weeks prior, resident #1 approached resident #4, exposed themselves to resident #4 and grabbed resident #4's hand in an attempt to force resident #4 to touch their private area.

Residents #3 and #4 stated that the home's administrator was made aware of the incidents when they occurred. The home did not report the incidents to [redacted] adult protective services as required.

Plan of Correction ***Directed [redacted] - 09/24/2025)***

The violation stems from the administrator not being made aware of incidents involving residents 3 and 4.

Immediate corrective action was taken by the administrator to fix the issue by educating the residents to report incidents to the administrator or staff of anything they are concerned of. The actions also included educating the staff on ensuring timely notification of incidents to the administrator that requires the Regional Department to be alerted within 24 hours of any reportable incident, and a report to the Department of Aging if warranted. This action also included a retrospective review of incidents from residents 3 and 4 and documenting findings in their RASP records.

Monitoring compliance will be led by the Administrator, with support from staff. The administrator will conduct monthly audits of incident reports, ensuring that any reportable incidents are escalated within 24 hours, and maintaining records in the facility's incident report folder.

(DIRECTED)

All staff, including the administrator, will receive training in abuse reporting and prevention from an outside source. The home will train all staff on the home's internal reporting policy and who is responsible for reporting resident abuse incidents 24/7 including weekends. Training shall be completed by 10-4-2025. In the future, the administrator will ensure that all suspected abuse is reported in accordance with Liberty Health adult protective services as required.

Proposed Overall Completion Date: 10/01/2025

18 - Compliance With Laws *(continued)*

Directed Completion Date: *10/04/2025*

Implemented [redacted] - 10/24/2025)

42b - Abuse

3. 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

On [redacted]/25 resident #1 cornered resident #2 near the elevator, pulled down their pants and asked resident #2 for a sex act. Resident #2 reported that resident #1 also attempted to grab their arm during the incident.
On 8/27/25 at approximately 5:15 p.m. resident #1 approached resident #2 in the outdoor smoking area, pulled their pants down and again exposed themselves to resident #2.
Resident #3 reported that approximately one week prior to these incidents, resident #1 entered the shower room while resident #3 was showering, exposed themselves to resident #3, and made a sexually vulgar remark to resident #3.
Resident #4 also reported that approximately a few weeks prior, resident #1 approached resident #4, exposed themselves to resident #4 and grabbed resident #4's hand in an attempt to force resident #4 to touch their private area.

Plan of Correction ***Directed [redacted] 09/24/2025)***

The violation stems from the administrator not being made aware of incidents involving residents 3 and 4.
Immediate corrective action was taken by the administrator to fix the issue by educating the residents to report incidents to the administrator or staff of anything they are concerned of. The actions also included educating the staff on ensuring timely notification of incidents to the administrator that requires the Regional Department to be alerted within 24 hours of any reportable incident, and a report to the Department of Aging if warranted. This action also included a retrospective review of incidents from residents 3 and 4 and documenting findings in their RASP records.
Monitoring compliance will be led by the Administrator, with support from staff. The administrator will conduct monthly audits of incident reports, ensuring that any reportable incidents are escalated within 24 hours, and maintaining records in the facility's incident report folder.
Resident #1 returned to the home on [redacted]/25 at approximately 3:30pm without prior communication from the hospital indicating that would occur. Since then, [redacted] has been on watch every 15 minutes to confirm that [redacted] is in compliance of not exuding aggressive behaviors, does not communicate with Resident #2, and continues to comply with the rules of the home, including taking [redacted] medication.
As of 9/21/25, Resident #1 continues to comply with the rules of the home, and does not communicate with Resident #2.

Proposed Overall Completion Date: 10/01/2025

(Directed)

In addition to the above noted plan: All staff including the Administrator will be trained in Resident

42b - Abuse (continued)

Rights and The Older Adults Protective Services Act by an outside source. Training shall be completed by 10-04-2025. The Administrator will observe interactions with staff members and residents in the homes on all shifts one day per week for 3 months. These observations will be on different days of the week, when different staff are working and different times of shift. These observations will be documented, and any problems will be addressed immediately. The home will complete 15-minute checks on resident #1 for any sexual behaviors with residents or staff.

Directed Completion Date: *10/04/2025*

***Not** Implemented [redacted] - 10/28/2025)*