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

November 14, 2025

[redacted], ADMINISTRATOR
ECUMENICAL ENTERPRISES, INC.
200 LAKE STREET
DALLAS, PA, 18612

RE: THE MEADOWS MANOR
200 LAKE STREET
DALLAS, PA, 18612
LICENSE/COC#: 24365

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/30/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE MEADOWS MANOR* **License #**: *24365* **License Expiration**: *09/20/2026*

Address: *200 LAKE STREET, DALLAS, PA 18612*

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

Administrator

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

Legal Entity

Name: *ECUMENICAL ENTERPRISES, INC.*

Address: *200 LAKE STREET, DALLAS, PA, 18612*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/04/1996* **Issued By**: *DLI*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *72* **Waking Staff**: *54*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *09/30/2025*

Inspection Dates and Department Representative

09/30/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served**: *66*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *47*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *6* **Have Physical Disability**: *0*

Inspections / Reviews

09/30/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/01/2025*

11/14/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/14/2025*

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

Inspections / Reviews *(continued)*

11/14/2025 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *11/14/2025*

Reviewer: [redacted] **Follow-Up Type:** *Not Required*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 11/26/2024, at 8:00 a.m. Resident #7, fell in their room and was transported to the Emergency room due to a head injury. The home did not report this incident to the department until 12/03/2024.

Plan of Correction ***Accept ([redacted] - 11/14/2025)***

Audit completed on 10/1 by Administrator and Administrative Assistant of Reportable Binder to ensure no further compliance issues presented. None noted.
The reportable incident policy was updated to reflect the recommendation of the on-site inspectors.
All designees who complete incident reports for the facility were in-serviced on new policy.
At time of submission, there have been no reportable conditions which fall under this policy change.
Please see Attachment #1

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

Implemented ([redacted] - 11/14/2025)

65f - Training Topics

2. 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.

Description of Violation

Staff person A and Staff person B did not receive training in medication self-administration, and instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan in training year 2024.

Plan of Correction ***Accept ([redacted] - 11/14/2025)***

Audit completed by Administrative Assistant and Administrator on 10/1 to ensure no further missing signatures were present. Both staff members were in-serviced on 10/1 and 10/2 on the following:
1) Medication Self Administration
2) Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation & support plan.
To ensure continued compliance, the Administrator will be responsible for a full audit prior to the end of the training year which runs January to December to ensure all required topics are covered by all required staff.
See Attachment #2

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

Implemented ([redacted] - 11/14/2025)

65g - Annual Training Content

3. 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:
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Description of Violation

Staff person A and Staff person B did not receive training in Resident Rights or The Older Adult Protective Services Act in training year 2024.

Plan of Correction ***Accept ([redacted] - 11/14/2025)***

Audit completed by Administrative Assistant and Administrator on 10/1 to ensure no further missing signatures were present. Both staff members were in-serviced on 10/1 and 10/2 on the following:
1) Resident Rights
2) The Older Adult Protective Services Act
To ensure continued compliance, the Administrator will be responsible for a full audit prior to the end of the training year which runs January to December to ensure all required topics are covered by all required staff.
See Attachment #3

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

Implemented ([redacted] - 11/14/2025)

121a - Unobstructed Egress

4. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

At approximately 9:39 a.m., the door to Stairwell B, which is used as an egress route and labeled as an exit, was equipped with a yellow strip banner secured across the door that had a Stop Sign on it. This sign causes confusion about whether the door can be used as an exit.

Plan of Correction ***Accept ([redacted] - 11/14/2025)***

During the on-site inspection the mesh stop sign that wrapped around the door was removed. Per the recommendation of on-site inspectors, the facility updated the signage to reflect:
1) Emergency Exit Only
2) Caution, Stairwell beyond Door
See Attachment #4

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

Implemented ([redacted] - 11/14/2025)

132g - Fire Drills Days/Times

5. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

132g - Fire Drills Days/Times *(continued)*

Description of Violation

The home routinely holds sleeping hours fire drills between 3:55a.m. and 4:00a.m. as evidenced by the following drills: 4/2/24 at 3:55a.m., 9/10/24 at 3:59a.m., and 4/24/25 at 3:55a.m.

Plan of Correction ***Accept (- 11/14/2025)***

Fire Drills were reviewed by the Administrator with the Maintenance Director on 10/2. Moving forward the Maintenance Director is to coordinate time and date with the Administrator prior to having a fire drill to ensure no patterns develop.
On 10/10/2025 an overnight fire drill was held at 2:55am.
The Administrator will be responsible to monitor for continued compliance.
See Attachment #5

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

Implemented (- 11/14/2025)

141b1 - Annual Medical Evaluation

6. Requirements

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

Description of Violation

The annual medical evaluation for resident #4, dated does not include if the resident's needs can be met in the care home, if the physician is in good standing, that the information provided was generated based on evaluation, and that the resident requires supervision with ADL's or IADL's or both.

Plan of Correction ***Accept (- 11/14/2025)***

On 10/1 the Resident Care Manager and LPN Supervisor completed an audit of all resident medical evaluations to ensure all documented medical evaluations are completed in full including a check box of "residents needs can be met in the care home, if the physician is in good standing, that the information provided was generated based on evaluation, and that the resident requires supervision with ADL's & IADL's or both".
The medical evaluation that was cited, was taken to the physician for completion of the missing check marks.
The medical evaluation policy was updated to include a list of individuals who can review the medical evaluation. Moving forward, it will be required that two out of that list of individuals will be required to review the DME to ensure area is addressed by physician.
See Attachment #6

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

Implemented (- 11/14/2025)

183e - Storing Medications

7. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

183e - Storing Medications *(continued)*

Description of Violation

Resident #1 had a bottle of Tylenol in the medication cart with an expiration date of 11/2018.

Plan of Correction ***Accept ([redacted] - 11/14/2025)***

Immediately upon discovery the medication was removed from the cart and destroyed, and replaced with house supplies.
Cart Audits performed by LPN Sup and RCM on 10/1 to ensure no further date concerns presented.
To ensure no future issues present, the facility updated the non-Pharmerica Delivery Receipt to reflect an initial date check of any medications received outside of facility pharmacy. All med-techs were in-serviced on this updated form on 10/3-10/6.
To ensure continued compliance, the administrator will conduct random monthly cart audits.
See Attachment #7

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

Implemented ([redacted] - 11/14/2025)

184a - Resident's Meds Labeled

8. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #2 had an open Humalog 100/ml pen, open in the cart. The medication did not have a pharmacy label on or in the resealable bag it was kept in.

Plan of Correction ***Accept ([redacted] - 11/14/2025)***

At time of inspection, per the recommendations of the inspectors the original pharmacy label was photocopied and attached to the bag immediately.
To ensure moving forward this does not occur again, the Insulin Storage and Safe Disposal Policy was updated to reflect if not already labeled, the original pharmacy label will be photocopied and placed with the pen or vial.
Med Tech Training and hands-on demonstration was held by the RCM and LPN Sup during the dates 10/6-10/10.
Cart Audit completed on 10/1 also double checked any other insulin we currently had to ensure no further violations.
To ensure ongoing compliance, the administrator will check this during random monthly cart audits.
See Attachment #8

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

Implemented ([redacted] - 11/14/2025)

185a - Implement Storage Procedures

9. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #5's glucometer was calibrated to 9/26/25 on 9/30/25.

185a - Implement Storage Procedures (continued)

Resident #2 has an order for blood glucose readings to be taken 4 times daily at 7:00 a.m., 11:00 a.m. 4:00 a.m. and 9:00 p.m. The resident had a blood glucose reading of 177 observed in the glucometer on 9/25/25 at 7:00 a.m., however the blood glucose reading was not documented on the resident's medication administration record.

Plan of Correction ***Accept ([redacted] - 11/14/2025)***

For violation #1 under 185a -
During Cart Audits completed on 10/1, RCM and LPN Sup also reviewed that date and time were calibrated on all glucometers to ensure no further violation presented.
The facility initiated weekly calibration checks for date and time on all glucometers which will be documented on Point Click Care eMAR.
Med Tech Training and review of PCC documentation was held the week of 10/6-10/10 to be implemented on 10/13.

For violation #2 under 185a -
Upon investigation, it was determined which Med Tech did not document the PRN use of the glucometer. That staff member was educated directly by the RCM.
During the Med Tech Training the week of 10/6-10/10 this was addressed with all Med Techs.
The RCM or LPN Sup will complete weekly glucometer checks x 4 weeks to ensure no further concerns are raised as it pertains to both violations.
To ensure continued compliance, the administrator will review PCC documentation and glucometer audits during random monthly cart audits.
See Attachment #9

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

Implemented ([redacted] - 11/14/2025)

187a - Medication Record

10. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
6. Dose.

Description of Violation

Resident #3 is prescribed Novolog 100 unitl/ml flexpen pen, inject units sub-q before meals and at bedtime as per sliding scale; 111-150 = 4, 151-200=10, 201-250 = 12, 251-300= 14, 301-999=18, >400 call MD with 3 days of numbers + dosing. However, Resident #1's medication administration record indicates 111-150=4, 351-999=18, it omits 301-351.

Plan of Correction ***Accept ([redacted] - 11/14/2025)***

While on-site inspectors were present, pharmacy was called and order was corrected. Please note, that while it was incorrect on orders tab, the administration eMAR was correct and no med errors were ever a result of the incorrect order.
On 10/1, cart audits were completed to ensure no further violations presented in regards to any sliding scales.
On 10/20, in-service was held for supervisors for the implementation of a new Sliding Scale verification policy which requires the double-check of a supervisor within 24 hours of a new sliding scale order and the requirement of the bi-weekly cart audit to offer oversight.
To ensure continued compliance, the administrator will conduct random monthly cart audits.

187a - Medication Record (continued)

See Attachment #10

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

Implemented (- 11/14/2025)

227c - Support Plan Revision

11. Requirements

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

Description of Violation

Resident #6 uses a bedside mobility device to get in and out of bed. Resident #6's support plan, dated , does not include the specific device to be used or if a cover is required to meet FDA guidelines.

Resident #8 utilizes a bed rail on the side of their bed, but their support plan dated , does not indicate if a cover is required to meet FDA guidelines.

Plan of Correction ***Accept (- 11/14/2025)***

The administrator pulled all RASP's of individuals utilizing the bedside mobility device and updated the wording to reflect the required items per DHS guidance.
Moving forward, the enabler checklist utilized internally was updated to reflect the necessary items to be addressed in the RASP as a checklist.
The Administrator will be responsible for random audits to ensure continued compliance.

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

Implemented (- 11/14/2025)