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

December 12, 2025

DUNLEVY MANOR LIVING LLC

RE: DUNLEVY MANOR LIVING
2218 PA-88
DUNLEVY, PA, 15432
LICENSE/COC#: 45597

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/09/2025 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: *DUNLEVY MANOR LIVING* **License #**: *45597* **License Expiration**: *09/23/2026*

Address: *2218 PA 88, DUNLEVY, PA 15432*

County: *WASHINGTON* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *DUNLEVY MANOR LIVING LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/03/2024* **Issued By**: *Dept. of Labor and Industry*

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**: *10/09/2025*

Inspection Dates and Department Representative

10/09/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *24* **Residents Served**: *13*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *13*

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

Have Mobility Need: *10* **Have Physical Disability**: *1*

Inspections / Reviews

10/09/2025 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/17/2025*

11/18/2025 - POC Submission

Submitted By: **Date Submitted**: *12/11/2025*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/21/2025*

Inspections / Reviews *(continued)*

12/05/2025 POC Submission

Submitted By: [redacted]
Date Submitted: *12/11/2025*
Reviewer: [redacted]
Follow Up Type: *Document Submission* **Follow Up Date:** *12/11/2025*

12/12/2025 Document Submission

Submitted By: [redacted]
Date Submitted: *12/11/2025*
Reviewer: [redacted]
Follow Up Type: *Not Required*

42b Abuse

1. 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], at approximately 8:30 am, staff person A was assisting resident [redacted] to the dining room in a wheelchair and noticed a [redacted] on the top of resident [redacted]'s left hand. Staff person A asked the resident what happened and the resident indicated "The big one was fighting with me." The resident identified the perpetrator as staff person B who was walking down the hall towards the dining room. The resident sustained a large, dark purple bruise that covered the top of [redacted] entire hand.

Plan of Correction ***Accept [redacted] - 12/05/2025)***

Violation: On [redacted], at approximately 8:30 a.m., staff person A observed a large, [redacted] on the top of resident [redacted]s left hand. Resident [redacted] reported that staff person B was responsible for the injury, stating "The big one was fighting with me."

1. Immediate Corrective Action Taken:
Staff person A immediately reported the allegation to the Administrator and the Supervisor in accordance with the facility's abuse reporting policy.
Resident [redacted] [redacted] hospice nurse was notified and was assessed for additional injuries.
Staff person B was immediately terminated from our facility.
The incident was reported to the appropriate state agencies and the resident's family/responsible party was notified on 10/7/2025.
A full internal investigation was initiated the same day.

2. Identification of Other Residents at Risk:
All residents were visually assessed for any signs of bruising, injury, or distress on 10/7/2025 by the Administrator and Supervisor.
No other residents were identified as being at risk or showing signs of possible abuse.

3. Systemic Changes to Prevent Recurrence:
All staff were re-educated on the facility's Abuse Prevention and Reporting Policy on 10/8/2025, emphasizing:

Mandatory immediate reporting of all allegations, suspicions, or observations of potential abuse.
Zero tolerance for abuse, neglect, or mistreatment.
Proper resident-handling techniques and professional boundaries.
The Administrator reviewed and updated the facility's abuse investigation protocol to ensure documentation and follow-up procedures are clearly outlined and consistently implemented.
The facility implemented a refresher in-service training for all staff on resident rights, dignity, and appropriate interactions by 11/12/2025.

4. Monitoring and Quality Assurance:

42b Abuse (continued)

The administrator or supervisor will document monthly interviews with at least two residents regarding their care and treatment. Documentation will be kept.
The Administrator or designee will conduct random unannounced rounds weekly for 60 days to monitor staff resident interactions and ensure compliance with abuse prevention policies.
Any allegations or incidents will be immediately reviewed and documented by the Administrator.
Findings will be discussed during monthly staff meetings for continued education and prevention.
Ongoing compliance will be monitored as part of the facility's quarterly Quality Assurance program.

5. Completion Date:
All corrective actions were completed or will be completed by November 12, 2025.

Licensee's Proposed Overall Completion Date: *11/21/2025*

Implemented - 12/12/2025)

225a - Assessment 15 Days

2. 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 assessment, dated , indicates "none" under dietary need, and does not include the diagnosis of and order of thickened liquids, as indicated in hospice records dated .

Repeat Violation:

Plan of Correction ***Accept - 11/18/2025)***

Violation: Resident s assessment, dated , indicates "none" under dietary need and does not include the diagnosis of or the physician's order for thickened liquids, as indicated in hospice records dated .

1. Immediate Corrective Action Taken:
The Administrator and Nurse/Designated Supervisor immediately reviewed Resident 's record upon discovery of the discrepancy.
Resident assessment and support plan were updated on 10/09/2025 to accurately reflect the diagnosis of dysphagia and the prescribed thickened liquid diet per hospice orders.
All direct care staff were notified and re educated on the resident's current dietary needs to ensure proper meal preparation and service.
Hospice records were reviewed and reconciled with the resident's chart to ensure all current orders are reflected in facility documentation.

2. Identification of Other Residents at Risk:
The Administrator reviewed all current residents' assessments and dietary sections on 10/9/2025 to ensure that any special dietary needs, restrictions, or physician orders are accurately documented and up to date.
No other discrepancies were found.

225a Assessment 15 Days (continued)

3. Systemic Changes to Prevent Recurrence:
The facility's assessment and documentation review process was revised to include a mandatory cross check with external provider records (e.g., hospice, home health, physician updates) any time new medical information or orders are received.
All staff responsible for completing or updating assessments were re trained on 11/12/2025 on the importance of ensuring accuracy and consistency between medical records and resident assessments.
A new procedure was implemented requiring the Administrator or designee to review and sign off on all assessments after any change in condition or outside service involvement.

4. Monitoring and Quality Assurance:
The Administrator or Supervisor will audit all resident assessments monthly for accuracy and completeness, ensuring all current medical diagnoses and dietary orders are properly documented.
Audit findings will be documented and reviewed at the monthly Quality Assurance meeting for continuous oversight.
Any discrepancies identified during audits will be corrected immediately and staff will receive follow up education as needed.

5. Completion Date:
All corrective actions were completed or will be completed by November 12, 2025.

Licensee's Proposed Overall Completion Date: *11/17/2025*

Implemented (- 12/12/2025)

227a - Support Plan 30 Days

3. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident support plan, dated , does not address that the resident is receiving hospice services, or include the contact information for the hospice agency or the type and frequency of services provided by the hospice agency.

Plan of Correction ***Accept - 11/18/2025)***

Violation: Resident s support plan, dated does not address that Resident is receiving hospice services, nor does it include the contact information for the hospice agency or the type and frequency of services provided by the hospice agency.

1. Immediate Corrective Action Taken:
Upon discovery of the omission, Resident support plan was immediately updated on 10/9/2025 to include:
The name and contact information of the hospice agency,
The type and frequency of hospice services provided, and
Documentation that the resident is currently receiving hospice care.
All care staff were notified and updated copies of the revised support plan were made available in the resident's chart and staff communication binder.

227a - Support Plan 30 Days (continued)

The hospice agency was contacted to verify and confirm current service details to ensure accuracy of the documentation.

2. Identification of Other Residents at Risk:
The Administrator and Supervisor reviewed all residents' support plans on 10/9/2025 to ensure that any residents receiving hospice or other external services had this information clearly documented.
No other residents were found to have missing or incomplete hospice or external service documentation.

3. Systemic Changes to Prevent Recurrence:
The Support Plan Review Checklist has been updated to include a specific item requiring verification of outside service providers (e.g., hospice, home health, therapy agencies).
Staff responsible for completing and reviewing support plans received retraining on 11/12/2025 regarding:

Proper documentation of all external service providers,
The need to include type, frequency, and contact details for each provider, and
The importance of maintaining coordination with outside agencies.
The Administrator will ensure that any time a resident is admitted to or discharged from hospice or other external care, the resident's support plan is updated within 24 hours to reflect the change.

4. Monitoring and Quality Assurance:
The Administrator or designee will audit 25% of all resident support plans monthly for three months to ensure hospice and other external services are documented correctly.
Audit results will be reviewed during monthly Quality Assurance meetings to identify trends or training needs.
Ongoing compliance will be monitored quarterly thereafter as part of the facility's continuous quality improvement program.

5. Completion Date:
All corrective actions were completed or will be completed by November 12, 2025.

Licensee's Proposed Overall Completion Date: *11/17/2025*

Implemented ██ - 12/12/2025)