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

December 23, 2025

MAPLE SHADE MEADOWS LP, LEGAL ENTITY
MAPLE SHADE MEADOWS LP

RE: MAPLE SHADE MEADOWS SENIOR LIVING
50 EAST LOCUST STREET
NESQUEHONING, PA, 18240
LICENSE/COC#: 20400

Dear MAPLE SHADE MEADOWS LP,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/05/2025 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: *MAPLE SHADE MEADOWS SENIOR LIVING* **License #**: *20400* **License Expiration**: *11/20/2026*

Address: *50 EAST LOCUST STREET, NESQUEHONING, PA 18240*

County: *CARBON* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *MAPLE SHADE MEADOWS LP*
Address: [redacted]
Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *10/14/2017* **Issued By**: *Nesquehoning*

Staffing Hours

Resident Support Staff: *46* **Total Daily Staff**: *160* **Waking Staff**: *120*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *11/05/2025*

Inspection Dates and Department Representative

11/05/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* **Residents Served**: *57*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *25* **Residents Served**: *17*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *74*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *57* **Have Physical Disability**: *0*

Inspections / Reviews

11/05/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/29/2025*

12/01/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/18/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/08/2025*

Inspections / Reviews *(continued)*

12/10/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/18/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/17/2025*

12/23/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *12/18/2025*

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

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

At 9:40 a.m., a binder containing personal information of resident's receiving hospice care was hanging on the medication room door of the secure memory care unit. The information was accessible to anyone in the SDU common room.

Plan of Correction ***Accept (- 12/10/2025)***

While inspectors were on site, binders were immediately moved to a secure area that is only accessible by staff.
Assistant Administrator will be responsible for continued compliance with regulation 2600.17
Binder was immediately removed; all staff was educated on regulation 2600.17 on 11/14/25.

Licensee's Proposed Overall Completion Date: *12/08/2025*

Implemented (- 12/23/2025)

103i - Outdated Food

2. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

At 3:30 p.m., the kitchen dried storage area contained a dented 50 oz. can of Campbells Cream of Celery Soup and a 6 lb. dented can of Dark Red Kidney Beans.

Plan of Correction ***Accept (- 12/10/2025)***

While inspectors were on site, dented cans were immediately removed from storage and disposed of. The kitchen manager will be responsible for continued compliance with regulation 2600.103i.
Kitchen manager will audit all food deliveries for continued compliance as well as audit weekly for dented can goods.

Licensee's Proposed Overall Completion Date: *12/08/2025*

Implemented (- 12/23/2025)

132g - Fire Drills Days/Times

3. 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.

Description of Violation

The home fire drill record does not include the full time that the drill was started. The fire drill records only indicate the hour and does not document the minute that the fire drill was started on the following drills: 10/1/25 at 2 p.m., 9/15/25 at 4 p.m., 8/15/25 at 11 a.m., and 7/31/25 at 9 p.m.

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

Plan of Correction ***Accept (█ - 12/10/2025)***

Administrator will ensure to correctly document hour and minutes on fire drill log.

Administrator will be responsible for fixing the problem.

Assistant administrator to also sign off on fire drill logs to ensure accuracy and compliance with 2600.132(g)

Licensee's Proposed Overall Completion Date: *12/08/2025*

Implemented (█ - 12/23/2025)

144c1 - Smoking Area Guidelines

4. Requirements

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

At 9:30a.m., two wicker chairs were located in the outdoor smoking section of the home. The chairs did not include a tag that they were fire resistant.

Plan of Correction ***Accept (█ - 12/10/2025)***

While inspectors were on site on 11/05/25, both wicker chairs were immediately removed by maintenance staff.

Maintenance manager will continue to ensure proper fireproof furniture is in use in smoking area.

A solid wood constructed bench was placed in smoking area for resident use.

Maintenance manager will perform quarterly audits to ensure proper furniture is in use.

Licensee's Proposed Overall Completion Date: *12/08/2025*

Implemented (█ - 12/23/2025)

185a - Implement Storage Procedures

5. 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 3's medication card containing Tramadol 50 mg had 14 pills in the card, but the controlled substance log indicated 15 pills remained in the pack.

Resident 4's Alprazolam 0.25 tab, pill number 88 was opened and had clear tape on the back to keep the pill in place.

Resident 5's Oxycodone HCL 5 Mg Tab, pill number 3 was opened and had clear tape on the back to keep the pill in place.

Resident 6's Lorazepam 1MG tab, pill number 46 was opened and had clear medical tape on the back to keep the pill

185a - Implement Storage Procedures (continued)

in place.

Plan of Correction ***Accept (- 12/10/2025)***

While inspectors were on site on 11/5/25, all improperly stored medications were disposed of. Director of Nursing re-educated all med techs on proper medication storage and placed a note on all medication carts instructing staff to immediately contact nurse management of any discrepancies.
The cause of the discrepancy for the incorrect pill count, was the staff member did not sign the medication out prior to administration. Staff member was re-educated on 11/5/25 (date of inspection) on ensuring medications are signed out immediately was popped from blister pack.
Administrator will be responsible for weekly cart audits to maintain compliance with regulation 2600.185a.

Licensee's Proposed Overall Completion Date: *12/08/2025*

Implemented (- 12/23/2025)

187d - Follow Prescriber's Orders

6. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident # 1 has an order to hold Metoprolol 12.5mg PO if SBP< 100 or HR <60. On the following dates resident was administered Metoprolol when HR was <60:

9/18/25 HR 45
9/24/25 HR 45

Plan of Correction ***Accept (- 12/01/2025)***

Director of Nursing re-educated all med techs on proper medication administration on November 14th.
Administrator will continue to do weekly chart audits, along with parameter books being initiated to maintain compliance with reg 187d.

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented (- 12/23/2025)

234a - Admission Support Plan

7. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident # 2 was admitted to the Secure Dementia Care Unit (SDCU) on The resident's initial support plan was not completed until more than 72 hours after the resident was admitted.

Plan of Correction ***Accept (- 12/10/2025)***

Administration and Nurse management reviewed support plan requirements related to 2600.234a, on 11/19/25.

234a - Admission Support Plan (continued)

Family advocate will be responsible for regularly performing weekly chart audits to ensure continued and ongoing compliance.
Administrator and Assistant Administrator will perform random audits on a monthly basis to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *12/08/2025*

Implemented (█ - 12/23/2025)