

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

May 1, 2026

[REDACTED], PRESIDENT
MAPLE VALLEY PERSONAL CARE HOME INC
2212 ANTHONY RUN ROAD
INDIANA, PA, 15701

RE: MAPLE VALLEY PERSONAL CARE
HOME
2212 ANTHONY RUN ROAD
INDIANA, PA, 15701
LICENSE/COC#: 42769

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/29/2025, 01/02/2026 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: MAPLE VALLEY PERSONAL CARE HOME License #: 42769 License Expiration: 03/08/2026
 Address: 2212 ANTHONY RUN ROAD, INDIANA, PA 15701
 County: INDIANA Region: WESTERN

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: MAPLE VALLEY PERSONAL CARE HOME INC
 Address: 2212 ANTHONY RUN ROAD, INDIANA, PA, 15701
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 05/01/2008 Issued By: Dept L & I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 35 Waking Staff: 26

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal Exit Conference Date: 01/02/2026

Inspection Dates and Department Representative

12/29/2025 - On-Site: [REDACTED]
 01/02/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 40 Residents Served: 33

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: 33
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 2 Have Physical Disability: 0

Inspections / Reviews

12/29/2025 Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/12/2026

03/20/2026 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 04/30/2026
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/25/2026

Inspections / Reviews *(continued)*

04/16/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/30/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 04/30/2026

05/01/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/30/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

51 - Criminal Background Check

1. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff Person A was hired on [REDACTED] however, the criminal background check on file was completed on [REDACTED]

Staff Person B was hired on [REDACTED] and did not have a criminal background check completed until [REDACTED]

Plan of Correction

Directed ([REDACTED] - 04/16/2026)

Staff Person A - [REDACTED] (611.52)

Staff Person B - Criminal Background Check was within the provisional hire period (OAPSA Act 28)

The Assistant To The Administrator will preform consistent background checks upon new employee hire dates.

UPDATE 03/25/2026: FOR STAFF A, A NEW UPDATED BACKGROUND CHECK WAS COMPLETED.

FOR STAFF B, PLEASE SEE THREE SUPPORTING DOCUMENTS TO SHOW THAT [REDACTED] WAS HIRED ON 12/3/2025 + [REDACTED] BACKGROUND CHECK WAS COMPLETED ON 12/10/2025 + [REDACTED] ORENTATION BEGAN ON 12/3/2025 AND WAS COMPLETED ON 12/12/2025. SO [REDACTED] DID NOT WORK ON THE FLOOR WITH ANY RESIDENTS UNTIL ORENTATION IS COMPLETE.

ALL NEW EMPLOYEE HIRES WILL HAVE A COMPLETED BACKGROUND CHECK THE DAY OF HIRE BEFORE ANY ORENTATION.

Proposed Overall Completion Date: 03/25/2026

DIRECTED PLAN:

Within 10 days of receipt of the plan of correction, the administrator or designee shall review all current staff records to ensure each staff person has a completed background check in accordance with the Older Adult Protective Services Act.

If the home chooses to employ a person on a provisional basis pending receipt of a criminal background check, per Regulatory Compliance Guide guidance, the following requirements must be met:

- The applicant shall have applied for a criminal history report and provided the home with a copy of the completed request forms.
- The home shall have no knowledge about the applicant that would disqualify the applicant from employment.
- The applicant shall swear or affirm in writing that the applicant is not disqualified from employment under the act.
- The provisionally employed applicant shall receive an orientation which provides information on policies, procedures and laws that address standards of proper care and recognition and reporting of abuse or neglect, or both, of recipients. This may be the training required by § 2600.65(b).
- The home shall regularly supervise the applicant carrying out assigned duties. The results of the observations shall be documented in the employee's personnel file.

51 Criminal Background Check (continued)

Directed Completion Date: 04/30/2026

Implemented () - 05/01/2026

60a - Staff/Support Plan

2. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

Resident #2 is prescribed Ondansetron ODT (Zofran) 8 mg, to be administered every four hours as needed for nausea and vomiting. A review of staffing schedules and staff interviews revealed that on 12/16/25, 12/17/25, 12/24/25 and 12/28/25 during the overnight shift from 11:00 PM to 6:00 AM, there was no staff person qualified to administer medication on duty in the home.

Plan of Correction

Directed () - 04/10/2026

Med Tech re training / re testing will happen with all night shift med tech(s) as required. Our State Issued Train The Trainer will properly train med tech(s). Med techs were also required to go through additional diabetic training from IRMC since inspection. These trainings were completed on 1/19/2026 and 1/20/2026.

UPDATE 03/25/2026: DON (DIRECTOR OF NURSING) signed up for the State Approved Medication Administration Train The Trainer Course (Please see supporting document)

Proposed Overall Completion Date: 05/29/2026

DIRECTED PLAN:

Within 10 days of receipt of the plan of correction and weekly thereafter: The administrator or designee shall review the staff schedule to ensure there is a staff person qualified to administer medication working in the home anytime a resident is in the building with a PRN medication order.

Directed Completion Date: 04/30/2026

Implemented () - 05/01/2026

65a - FS Orientation 1st Day

3. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.

65a - FS Orientation 1st Day (continued)

7. Telephone use and notification of emergency services.

Description of Violation

Staff Person A, hired [REDACTED], and Staff Person B, hired [REDACTED] did not have documentation indicating the date the first day of orientation was completed; therefore, it is unknown whether orientation was completed on or before the first day of work as required.

Plan of Correction

Accept ([REDACTED] - 03/20/2026)

Staff Person A and Staff Person B were in fact properly orientated and initials were placed by each item to assure they understood. A start date has been added to our orientation checklist to verify the orientation process and proper timing. Our Operations Manager has implemented these updates to our hiring and onboarding process.

Licensee's Proposed Overall Completion Date: 03/12/2026

Implemented ([REDACTED] - 05/01/2026)

65b - Rights/Abuse 40 Hours

4. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff Person A, hired [REDACTED] and Staff Person B, hired [REDACTED] did not have documentation indicating the date orientation was completed within 40 scheduled working hours; therefore, it is unknown whether orientation was completed within the required timeframe.

Plan of Correction

Accept ([REDACTED] - 03/20/2026)

Staff Person A and Staff Person B were in fact properly orientated within 40 scheduled working hours and initials were placed by each item to assure they understood. A start date and completion date have been added to our orientation checklist to verify the orientation process is properly completed within 40 scheduled hours. Our Operations Manager has implemented this request for information to our hiring and onboarding process.

Licensee's Proposed Overall Completion Date: 03/12/2026

Implemented ([REDACTED] - 05/01/2026)

81b - Resident Personal Equipment

5. Requirements

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 12/29/25, Resident #2's bedrail was not secured to the bed allowing movement and posed a fall or suffocation hazard.

81b - Resident Personal Equipment (continued)

Plan of Correction

Directed () - 04/16/2026

Upon finding out the bedrail was not to correct state standards, it was immediately removed and the resident's family was notified. A new state standard bed rail was ordered and properly installed and secured to the bed frame. Administrator will pre-approve bedrails prior to use.

UPDATE 03/25/2026: PLEASE SEE THE ATTACHED SUPPORTING DOCUMENT. FAMILY WAS NOTIFIED ON STATE REQUIREMENTS FOR A BED RAIL. IT WAS RECEIVED AND PROPERLY INSTALLED BY OUR OPERATIONS MANAGER ON 01/07/2026.

Proposed Overall Completion Date: 03/25/2026

DIRECTED PLAN:

Within 10 days of receipt of the plan of correction: The administrator or designee shall inspect all bedside mobility devices used by residents in the home to ensure they are installed according to the manufacturer's instructions and are free from entrapment or strangulation hazards.

Directed Completion Date: 04/30/2026

Implemented () - 05/01/2026

88a - Surfaces

6. Requirements

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 12/29/25, the metal faceplate covering the wander guard alarm pad at the front door was unsecured, causing a corner to protrude outward and posing a potential laceration hazard.

Plan of Correction

Accept () - 04/16/2026

This issue was fixed on the day of inspection. Maintenance will continue to do proper inspections monthly to insure secure the faceplate is tight and secure.

UPDATE 03/25/2026: (), MAINTENANCE PERSONEL SECURED THE METAL FACEPLACE COVERING AS DIRECTED ON 12/31/2025.

Licensee's Proposed Overall Completion Date: 03/25/2026

Implemented () - 05/01/2026

96a - First Aid Kit

7. Requirements

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

On 12/29/25, the first aid kit in the medication room was missing scissors, gloves, a thermometer, and tape, and the first aid kit in the closet was missing scissors, a breathing shield, eye coverings, and a thermometer.

96a - First Aid Kit (continued)

Plan of Correction

Accept () - 04/16/2026

All first aid kits have been inventoried and contain state required items. DON (Director of Nursing) will inspect monthly to ensure future compliance.

UPDATE 03/25/2026: DON (DIRECTOR OF NURSING) CORRECTED THE VIOLATION ON 01/02/2026.

Licensee's Proposed Overall Completion Date: 03/25/2026

Implemented () - 05/01/2026

103f - Refrigerator/Freezer Temps

8. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 12/29/25, there was no thermometer in the refrigerator in the activity room.

Plan of Correction

Accept () - 04/16/2026

There was a thermometer in bottom of fridge that went unnoticed by inspectors. All refrigerators and freezers have thermometers. Kitchen Manager will monitor all thermometers to ensure proper working status.

UPDATE 03/25/2026: THERMOMETER FREQUENCY IS CHECKED TWICE DAILY, ONCE AT THE START OF THE DAY AND ONCE AT THE END OF THE DAY.

THE TEMPERATURE READING OF THE THERMOMETER CURRENTLY IN THE REFRIGERATOR IS 37 DEGREES F.

Licensee's Proposed Overall Completion Date: 03/25/2026

Implemented () - 05/01/2026

123b - Emergency Procedures Posted

10. Requirements

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

On 12/29/25, the local municipality's emergency plan was not posted in a conspicuous and public place in the home.

Plan of Correction

Accept () - 03/20/2026

The local municipality's emergency plan was posted in a public place with our facilities emergency plan that went unnoticed by the inspector the day of inspection.

Plan of correction to prevent any future issues: we added two labels to the front of the Emergency Plans Clear Cover; FACILITY EMERGENCY PLAN and ARMSTRONG TWP. EMERGENCY PLAN

Administrator will monitor monthly to ensure future compliance.

Licensee's Proposed Overall Completion Date: 03/12/2026

123b - Emergency Procedures Posted *(continued)*

Implemented (█) - 05/01/2026

185a - Implement Storage Procedures

11. 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 #4 is prescribed Humalog 100 units/mL KwikPen administered per sliding scale before meals and at bedtime as follows: blood glucose 180–240 = +1 unit; 241–300 = +2 units; 301–360 = +3 units; 361–440 = +4 units; and over 420 = +5 units with physician notification required. Resident #4 utilizes a Dexcom Continuous Glucose Monitoring (CGM) device for ongoing glucose monitoring. However, staff were unable to recall or provide documentation reflecting the resident's blood glucose history obtained from the device.

Plan of Correction

Accept (█) - 03/20/2026

DON (Director of Nursing) was able to obtain hourly reports of Dexcom as needed. The Dexcom Continuous Glucose Monitoring device is able to be plugged in to the computer. Med Tech staff are also able to log into the Dexcom site at anytime and see past and current Dexcom readings.

█ Pharmacy was contacted in regards to the question of 420 units = +5 units (Clarification obtained, along with a new order and updated MAR.)

Our Med Tech Staff have also received additional Diabetes with specific Dexcom training on 1/19/2026 and 1/20/2026. Our Director of Nursing (DON) will continue to monitor these practices moving forward to ensure proper compliance.

Licensee's Proposed Overall Completion Date: 03/12/2026

Implemented (█) - 05/01/2026

187a - Medication Record

12. Requirements

2600.

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

Description of Violation

Resident #3 was prescribed Loperamide 2 mg, one tablet every four hours as needed for diarrhea; however, the resident's December 2025 medication administration record (MAR) indicated Loperamide 2 mg, two capsules twice daily as needed for diarrhea.

Resident #3 was prescribed Banophen 25 mg, one tablet every eight hours as needed for allergies; however, the medication was not listed on the resident's December 2025 medication administration record (MAR).

187a - Medication Record (continued)

Plan of Correction

Accept (█ - 03/20/2026)

Both of these medications came from a pervious facility. All medications that come from another facility are sent back to our pharmacy once █ sends us all prescribed medication and medi-packs to eliminate confusion of old vs. new meds, and to ensure proper dates, correct dosage as well as any medications that may have been discontinued by physician(s).

DON (Director of Nursing) will compare and confirm all incoming medication lists with all physical medications brought to us and notify the Resident's physician and well as █ Pharmacy to ensure proper MARs.

Licensee's Proposed Overall Completion Date: 03/12/2026

Implemented (█ - 05/01/2026)

187d - Follow Prescriber's Orders

13. Requirements

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

Description of Violation

On 12/8/25, Resident #3 was prescribed Rexulti 1 mg, one tablet once daily for mood; however, as of 12/29/25, the medication has not been administered as it is not available in the home.

Plan of Correction

Accept (█ - 04/16/2026)

Resident # 3 family member / Medical POA did not want █ to take due to the cost of medication being over \$314.00. PCP was notified and this medication was discontinued properly per █ PCP physician's signature.

Director of Nursing (DON) will ensure that medication questions or concerns per a Residents' POA will only be changed and/or discontinued with a proper order request and physician's signature.

UPDATE 03/25/2026: THE MEDICATION WAS DISCONTINUED AND SIGNED BY PHYSICIAN ON 12/10/2025. PLEASE SEE SUPPORTING DOCUMENTATION.

OUR MED TECHS WERE EDUCATED DURINIG A MANDTORY IN-SERVICE ON 01/19/2026 REGARDUING MEDICATION CHANGES AND MEDICATION DISCONTINUATIONS.

Licensee's Proposed Overall Completion Date: 03/25/2026

Implemented (█ - 05/01/2026)

224a - Preadmission Screen Form

14. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #2 was admitted to the home on █; however, the resident's preadmission screening form was completed on █

224a - Preadmission Screen Form (continued)

Plan of Correction

Accept ([REDACTED]) - 04/16/2026

Administrator will prepare and review all preadmission screens prior to admission and will properly sign before or upon acceptance of a new resident admission.

UPDATE 03/25/2026: ON 01/26/2026, ADMINISTRATOR EDUCATED DON IN REGARDS TO COMPLETIING A PRE-ADMISSIONS SCREENING WITHIN 30 DAYS PRIOR TO ADMISSION OF FACILITY.

Licensee's Proposed Overall Completion Date: 03/25/2026

Implemented ([REDACTED]) - 05/01/2026

227d - Support Plan Medical/Dental

15. Requirements

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #2's Resident Assessment Support Plan, dated [REDACTED], did not include the resident's use of a bedrail or hospice and physical therapy services under formal supports.

Plan of Correction

Accept ([REDACTED]) - 04/16/2026

Changes to Resident Assessment Support Plans will be properly updated by our DON (Director of Nursing) upon necessary changes once we are properly notified per written orders.

UPDATE 03/25/2026: PATIENT WAS NOT ON HOSPICE, PT OR NEEDED A BEDRAIL AT THAT TIME OF [REDACTED]

Licensee's Proposed Overall Completion Date: 03/25/2026

Implemented ([REDACTED]) - 05/01/2026