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

March 30, 2026

[redacted]
CHRIST THE KING MANOR INC
[redacted]

RE: CHRIST THE KING MANOR
1100 WEST LONG AVENUE
DUBOIS, PA, 15801
LICENSE/COC#: 44864

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/20/2026 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: *CHRIST THE KING MANOR* **License #**: *44864* **License Expiration**: *06/20/2026*

Address: *1100 WEST LONG AVENUE, DUBOIS, PA 15801*

County: *CLEARFIELD* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *CHRIST THE KING MANOR INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/15/1996* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *93* **Waking Staff**: *70*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *01/20/2026*

Inspection Dates and Department Representative

01/20/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served**: *52*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *ALZ* **Capacity**: *20* **Residents Served**: *17*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *52*

Diagnosed with Mental Illness: *35*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *41*

Have Physical Disability: *0*

Inspections / Reviews

01/20/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/21/2026*

02/20/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/27/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/27/2026*

Inspections / Reviews *(continued)*

02/25/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/27/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/27/2026*

03/30/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *03/27/2026*

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

23a - Activities of Daily Living Assistance

1. 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

Resident [redacted] most recent assessment and support plan completed on [redacted] indicates a care need for aggression of, "Resident can become verbally aggressive at times. Arguing with other residents" and a plan to meet this need of, "staff will redirect resident and attempt to deescalate any confrontations safely for all involved. However, on [redacted], at approximately 1:20 p.m., resident [redacted] was involved in a physical confrontation involving residents Resident [redacted] and [redacted] Resident [redacted] struck, resident [redacted] multiple times in the neck and head area of [redacted] person. Resident [redacted] subsequently pushed resident [redacted] causing [redacted] to fall backwards into resident [redacted] Both residents fell to the floor resulting in pain and injury to both residents [redacted] and [redacted] and

Resident [redacted] date of admission [redacted], has a diagnosis of [redacted] with early onset, with a plan to meet this psychological need of, "staff will reorient, redirect, and offer emotional support as needed". However, on [redacted], at approximately 1:20 p.m., Resident [redacted] was involved in a physical confrontation involving residents [redacted] and [redacted] Resident [redacted] entered resident [redacted]s room to expel resident [redacted] and [redacted] from resident [redacted]s room. The confrontation escalated resulting in resident [redacted] striking resident [redacted] multiple times in the neck and head area of [redacted] person. Resident [redacted] pushed resident [redacted] causing [redacted] to fall backwards into resident [redacted] Both residents fell to the floor resulting to pain and injury to both residents [redacted] and [redacted]

REPEAT VIOLATION: [redacted] et, al.

REPEAT VIOLATION: [redacted], et, al.

Plan of Correction ***Accept[redacted] 02/20/2026)***

The residents were immediately separated and assessed by PCA and Medtech. Families were called and resident 1&2 were sent to the ER and returned back without significant injury and no new orders.
Resident one was reassessed by Wellness director on 12/15/25. PCP aware of situation. Resident 1 was reassessed by Sandy Stom CRNP on 1/6/26 and states [redacted] is now requiring more assistance and much redirection, more than baseline. Resident was given a 30 day notice on 2/6/25 and family chose to voluntarily admit to Geri psych on 2/10. Wellness director will continue to update care plans and check monthly for 3 months and more frequently if any behaviors occur. We will review in quarterly risk management meeting.

Licensee's Proposed Overall Completion Date: *02/19/2026*

Implemented [redacted] - 03/30/2026)

42c - Treatment of Residents

2. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [redacted], an act of physical aggression occurred on the Alzheimer Unit near the unit's dining hall area. The incident involved three residents, resulting in two of the residents experiencing significant physical pain and sustaining injuries that required medical attention.

42c Treatment of Residents (continued)

The residents involved are as follows:

Resident [redacted] date of admission [redacted] has a diagnosis of unspecified [redacted], unspecified severity, without [redacted]. With a plan to meet this psychological need of, "resident resides in the secured dementia unit for safety and supervision. Staff are to redirect and reorient as needed and provide emotional support."

Resident [redacted] date of admission [redacted] has a diagnosis of unspecified [redacted], unspecified severity, without [redacted]. With a plan to meet this psychological need of, "resident receives medications as ordered and resides in the secured dementia unit for safety and supervision. Staff are to redirect and reorient resident as needed".

Resident [redacted] date of admission [redacted], has a diagnosis of [redacted] with a plan to meet this psychological need of, "staff are to redirect, reorient, and provide emotional support as needed".

However, at approximately 1:20 p.m., Residents [redacted] and [redacted] entered resident [redacted]s private room without permission. Moments later, resident [redacted] entered resident [redacted]s private resident room in an attempt to escort residents [redacted] and [redacted] out of the private room.

While in the room, resident [redacted] became physically aggressive and struck resident [redacted] multiple times in the neck and head area with [redacted] hand. Resident [redacted] then pushed resident [redacted] causing [redacted] to fall backward into resident [redacted] Both resident [redacted] and [redacted] fell backwards out of resident [redacted]s private resident room and into the hallway adjacent to the [redacted] dining area.

As residents [redacted] and [redacted] fell to the floor, both struck their heads against the hallway wall / floor. Resident [redacted] sustained a contusion to [redacted] right temple and required the application of ice to address swelling and pain. Resident [redacted] complained of left wrist and right hip pain and sustained a skin tear to [redacted] left arm. Both residents complained of significant pain and were tearful for approximately 15 minutes awaiting transport to Duboise hospital.

Staff member/s contacted DuBois Emergency Medical Services, who transported resident [redacted] to DuBois Hospital. Resident [redacted] was evaluated by the hospital and released back to the home the same day. Staff member/s also contacted resident [redacted] son, who transported resident [redacted] to DuBois Hospital. Resident [redacted] was evaluated and discharged, returning to the home on the same date.

Plan of Correction ***Accept [redacted] - 02/25/2026)***

The direct care staff separated the residents immediately on 12/13/25 and the families and Physicians were notified. Resident's 1&2 were sent to the hospital on 12/13/25 and returned later on 12/13/25 without severe bodily injury.
The Wellness director will monitor behavior documentation and compare with the support plans starting 1/20/26 weekly for a month then monthly for 3 months.
The administrator will review the updated support plans on 1/20/26 and compare to the behavioral notes for 3 months to ensure we are continuing to update the support plans as needed.
We will review the findings in our quarterly Risk management meetings.

Licensee's Proposed Overall Completion Date: *03/20/2026*

Implemented [redacted] 03/30/2026)

42s - Privacy

3. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

Multiple common areas of the home were being video recorded to include the [redacted] dining area. However, there was no signage indicating video recording was in progress.

Plan of Correction ***Accept ([redacted] - 02/25/2026)***

The administrator immediately posted security camera signage on 1/20/26 in all entry ways hallways and common areas.
The administrator will do weekly walk throughs in the units starting 1/20/26 to ensure the signage is still present and then monthly for 3 months and will continue to have acknowledgement forms of security camera's signed upon admission.
We will review the findings in Risk management meetings to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *03/20/2026*

Implemented [redacted] - 03/30/2026)

187a - Medication Record

4. 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 is prescribed [redacted] take one half tablet by mouth three times a day. The resident was administered this medication on [redacted] at 2:00 p.m. However, on [redacted] at 2:00 p.m. The Medication's Administration was not indicated on the resident's December 2025, Medication Administration Record for the corresponding date.

Plan of Correction ***Accept [redacted] - 02/25/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 1/20/2026 by the Wellness director to enter a late entry for the medication administration.

To enhance the currently compliant operations, on 01/20/2026 the Wellness director re educated The Med Tech the policies and procedures regarding medication administration.

Effective 01/20/2026 the Wellness Director will perform weekly reviews of MAR's, for 1 month then monthly for 3 months to maintain ongoing compliance. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally in our Risk Management meeting for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *03/20/2026*

Implemented [redacted] - 03/30/2026)

187c - Refusal of Medication

5. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident is prescribed [redacted] tablet take one tablet by mouth every eight hours is needed for anxiety. The medication was attempted to be administered due to agitation on multiple dates to include [redacted] at 8:13 p.m., and [redacted], at 3:45 a.m. Resident [redacted] refused the attempted administrations. However, the home failed to notify the prescribing physician.

Resident [redacted] has refused multiple medications on multiple dates to include, [redacted], take one casual by mouth twice daily on [redacted] at 2:00 p.m., and [redacted] capsule Take one capsule by mouth once daily at on [redacted]. However, the home failed to notify the prescribing physician.

Plan of Correction ***Accept [redacted] 02/25/2026)***

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 01/20/2026 by the Administrator to inform all Med Tech's that if someone refuses any medication the Physician will be notified within 24 hours.

To enhance the currently compliant operations, on 01/20/2026 the Wellness Director will monitor any med refusals during [redacted] Weekly MAR audits for 1 month and monthly for 3 months. Findings will be reviewed in Risk Management, for continued improvement purposes.

Licensee's Proposed Overall Completion Date: *03/20/2026*

Implemented [redacted] - 03/30/2026)

227c - Support Plan Revision

6. 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 [redacted]s most recent assessment and support plan completed on [redacted], indicates a care need for Hallucinations of, "not applicable". However, the resident has hallucinated on multiple dates, to include, on [redacted] at 9:19 p.m., when resident was observed attempting to "step over nonexistent objects." and on [redacted] when resident repeatedly stated, [redacted] was in there and was sick". Resident care notes indicate resident #1appeared to be [redacted].

Plan of Correction ***Accept [redacted] - 02/25/2026)***

The resident was assessed by Wellness director immediately 1/20/2026 and the Support plan was updated as [redacted] did not have a diagnosis of [redacted]. The Dr. was notified on 1/20/2026 of the recent behavior.

The Wellness Director will monitor behavioral changes and update support plans starting 1/20/2026 weekly for 1 month then monthly for 3 months.
Any findings will be discussed in our Risk management meeting.

227c - Support Plan Revision (continued)

Updates will be ongoing as needed and annually.

Licensee's Proposed Overall Completion Date: *03/20/2026*

Implemented [redacted] - 03/30/2026)