Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

March 30, 2026

MESSIAH HOME INC

RE: MESSIAH LIFEWAYS AT MESSIAH VILLAGE
100 MT. ALLEN DRIVE
MECHANICSBURG, PA, 17055
LICENSE/COC#: 34291

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/04/2026 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MESSIAH LIFEWAYS AT MESSIAH VILLAGE* **License #**: *34291* **License Expiration**: *11/03/2026*

Address: *100 MT. ALLEN DRIVE, MECHANICSBURG, PA 17055*

County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *MESSIAH HOME INC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *194* **Waking Staff**: *146*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *02/04/2026*

Inspection Dates and Department Representative

02/04/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *190* **Residents Served**: *134*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Laurel Upper* **Capacity**: *76* **Residents Served**: *39*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *134*

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

Have Mobility Need: *60* **Have Physical Disability**: *1*

Inspections / Reviews

02/04/2026 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/28/2026*

03/16/2026 - POC Submission

Submitted By: **Date Submitted**: *03/26/2026*

Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/27/2026*

Inspections / Reviews *(continued)*

03/30/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *03/26/2026*

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

100b - Removal Snow/Obstructions

1. Requirements

2600.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On [redacted] at approximately 9:45am there was an approximate 4-inch accumulation of snow and ice outside on the pathway from the dining room exit.

Plan of Correction ***Accept ([redacted] - 03/16/2026)***

On January 30, 2026, the Mechanicsburg area received a significant snowfall due to a winter storm. During the snow removal process across the entire Messiah Lifeways campus, the exit located outside one of the personal care home dining rooms was inadvertently not cleared.

Upon discovery of the snow accumulation, the landscaping team was immediately notified. The area was promptly shoveled, and a clear and safe path of egress was established to ensure accessibility in the event of an emergency.

During all future snow events, the grounds team will ensure that all exterior exits and walkways throughout the campus are cleared of snow, ice, and any other obstructions to maintain safe and accessible egress.

The Grounds Supervisor or the Personal Care Home Administrator (PCHA) will conduct an audit within 24 hours of the start of each snow event to verify that all exits and walkways have been properly cleared.

In addition, monthly environmental audits will continue to be conducted to ensure all exits remain free from obstruction. These audits will occur during routine monthly rounds held on the third Tuesday of each month.

100b - Removal Snow/Obstructions (continued)

Licensee's Proposed Overall Completion Date: *04/01/2027*

Implemented - 03/30/2026)

121a - Unobstructed Egress

2. 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

On at approximately 9:45am the egress from the dining room could not be fully open due to the snow and ice blocking the doorway.

On at approximately 9:45am the egress at Stairwell 11G were unable to open due to snow and ice or another object blocking or otherwise impeding the door from opening.

Plan of Correction ***Accept (03/16/2026)***

On January 30, 2026, the Mechanicsburg area received a significant amount of snowfall due to a winter storm. During the storm, precipitation accumulated and became trapped within the seal of Door 11, which is designated as an emergency exit door for the Personal Care Home at Messiah Lifeways.
As a result of the accumulation and freezing conditions, the door did not open easily when tested. On February 4,

121a Unobstructed Egress (continued)

2026, at approximately 9:45 a.m., during a partial survey conducted by DHS, the door was found to be difficult to open.

Immediately upon identification of the concern, the maintenance team evaluated Door 11. The door was able to be opened with additional force and was determined to have been frozen shut due to weather related conditions. The door seal and surrounding area were assessed, and the obstruction was addressed. Since that time, the door has been functioning properly and opens without difficulty.

Following any future snow event, all doors designated and labeled as emergency exits will be tested for proper functionality as part of the post storm audit conducted by the Grounds Supervisor or the Personal Care Home Administrator (PCHA). This will ensure that doors open easily and are not impacted by snow, ice, or freezing conditions.

In addition, all exit doors will be tested monthly as part of the ongoing environmental audit process to verify continued proper operation and to identify and address any potential concerns related to door functionality.

Licensee's Proposed Overall Completion Date: *04/01/2027*

Implemented [redacted] 03/30/2026)

186b - Medication Used by Resident

3. Requirements

2600.
186.b. Prescription medications shall be used only by the resident for whom the prescription was prescribed.

Description of Violation

On [redacted] at 8:45am Resident [redacted] was administered the following medications which were prescribed to and belonged another resident:

- [redacted]
- [redacted]

186b Medication Used by Resident (continued)

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

Plan of Correction ***Accept [redacted] - 03/16/2026)***

This incident occurred on the secure dementia unit. The resident who received the incorrect medication was experiencing multiple behavioral episodes and required frequent redirection and support to reduce anxiety. During medication administration, the nurse was interrupted several times by both residents and staff. While responding to the immediate behavioral needs of the resident, the nurse inadvertently administered medications that had been prepared for another resident. The interruption and shift in focus during the medication pass contributed to human error, resulting in the medications being given to the wrong resident.

Contributing factors included environmental distractions, interruption during medication preparation and administration, and the high behavioral acuity on the unit at the time of the incident.

The nurse who administered the incorrect medication immediately notified upper management upon recognizing the error. The resident's physician and Power of Attorney (POA) were promptly notified.

Per physician direction, the resident's morning medications were held. Vital signs were monitored every hour for six hours, followed by every eight hours for the next 24 hours. Staff were instructed to closely observe the resident for signs of lethargy or any other adverse effects for a full 24 hour period. Staff were further directed that if any new or concerning symptoms developed, they were to contact the primary care provider immediately or call 911, depending on the severity of the symptoms.

The facility reported the medication error to the Department of Human Services within the required 24 hour reporting timeframe. In addition, a follow up call was conducted with the POA within 24 hours of the incident to review the resident's status and address any ongoing questions or concerns.

The nurse involved in the medication error received immediate education from the Director of Nursing (DON) on the five rights of medication administration and strategies to manage interruptions during medication passes. The nurse who reported the error was also verbally counseled regarding proper medication administration, adherence to the five rights, and techniques for handling interruptions. In addition, all nursing staff who perform medication administration will receive re education on the five rights, proper resident identification, and strategies for managing interruptions during medication passes. Direct care staff will be educated on the importance of not interrupting Licensed Practical Nurses (LPNs) or Medication Technicians (MTs) during medication passes for non urgent requests. The nurse was further instructed on proper handling and storage of medications in the medication cart while addressing immediate resident needs, to prevent any future mix ups. Medication audits will be conducted for a period of one year to ensure that distractions are minimized and managed appropriately during all medication passes.

Licensee's Proposed Overall Completion Date: *04/01/2027*

186b - Medication Used by Resident *(continued)*

Implemented - 03/30/2026)

187d - Follow Prescriber's Orders

4. Requirements

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

Description of Violation

Resident is prescribed take 1 tablet by mouth twice daily for and and for depression, take 1 capsule (each) by mouth twice daily. On at 8:45am the resident was administered 10 mg of and 60mg of the .

Plan of Correction ***Accept - 03/16/2026)***

This incident occurred on the secure dementia unit. The resident who received the incorrect medication was experiencing multiple behavioral episodes and required frequent redirection and support to reduce anxiety.

During medication administration, the nurse was interrupted several times by both residents and staff. While responding to the immediate behavioral needs of the resident, the nurse inadvertently administered medications that had been prepared for another resident. The interruption and shift in focus during the medication pass contributed to human error, resulting in the medications being given to the wrong resident.

Contributing factors included environmental distractions, interruption during medication preparation and administration, and the high behavioral acuity on the unit at the time of the incident.

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The facility reported the medication error to the Department of Human Services within the required 24-hour reporting timeframe. In addition, a follow-up call was conducted with the POA within 24 hours of the incident to review the resident's status and address any ongoing questions or concerns.

187d - Follow Prescriber's Orders (continued)

The nurse involved in the medication error received immediate education from the Director of Nursing (DON) on the five rights of medication administration and strategies to manage interruptions during medication passes. The nurse who reported the error was also verbally counseled regarding proper medication administration, adherence to the five rights, and techniques for handling interruptions. In addition, all nursing staff who perform medication administration will receive re-education on the five rights, proper resident identification, and strategies for managing interruptions during medication passes. Direct care staff will be educated on the importance of not interrupting Licensed Practical Nurses (LPNs) or Medication Technicians (MTs) during medication passes for non-urgent requests. The nurse was further instructed on proper handling and storage of medications in the medication cart while addressing immediate resident needs, to prevent any future mix-ups. Medication audits will be conducted for a period of one year to ensure that distractions are minimized and managed appropriately during all medication passes.

Licensee's Proposed Overall Completion Date: *04/01/2027*

Implemented ███ - 03/30/2026)