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

March 23, 2026

[redacted]
PREMIER OAKWOOD TERRACE OPERATING LLC
[redacted]

RE: OAKWOOD TERRACE
400 GLEASON DRIVE
MOOSIC, PA, 18507
LICENSE/COC#: 22661

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/10/2026 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *OAKWOOD TERRACE* **License #**: *22661* **License Expiration**: *11/20/2026*

Address: *400 GLEASON DRIVE, MOOSIC, PA 18507*

County: *LACKAWANNA* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *PREMIER OAKWOOD TERRACE OPERATING LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/19/1998* **Issued By**: *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *61* **Waking Staff**: *46*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *02/10/2026*

Inspection Dates and Department Representative

02/10/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *58* **Residents Served**: *44*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *24* **Residents Served**: *16*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *41*

Diagnosed with Mental Illness: *1*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *17*

Have Physical Disability: *0*

Inspections / Reviews

02/10/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/14/2026*

03/23/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/23/2026*

Reviewer: [redacted] **Follow-Up Type**: *Bypass Document Submission*

Inspections / Reviews *(continued)*

03/23/2026 Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *03/23/2026*

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

At approximately 9:15 a.m. the emergency exit in Birch Hall had an approximate ¼ inch of snow outside of the door.

Plan of Correction ***Accept [redacted] 03/23/2026)***

1. On 2/10/26 immediately upon identification of the concern, maintenance staff removed the snow accumulation from outside the Birch Hall emergency exit door to ensure the exit pathway was clear and unobstructed for safe emergency egress.
Additionally, all exterior emergency exits, walkways, ramps, steps, recreational areas, and fire escape pathways throughout the home were immediately inspected to ensure they were free of snow, ice, or other obstructions.

2. On 2/11/26 a Snow and Ice Monitoring Log has been implemented requiring maintenance to check all emergency exits and exterior walkways multiple times during snowfall events and immediately after accumulation to ensure pathways remain clear. This log is included.

On 2/11/26 the home reviewed snow and ice removal procedures with maintenance staff. All emergency exits, walkways, ramps, and fire escape areas will be inspected and cleared during winter weather events to ensure they remain free of snow, ice, and other obstructions. This newly updated policy is included.

Additionally, checking sidewalks for any snow accumulation was added to our maintenance directors daily focus rounds tool. This tool is included.

3. On 2/11/26 maintenance staff have been re-educated regarding the requirement under 55 Pa. Code §2600.100(b) to ensure that all exterior exits and walkways remain free of snow, ice, and obstructions. This training is included.

Additionally, the Maintenance Director and Executive Director was trained on the updated policy and snow and ice monitoring log. This training is included.

4. The Executive Director and Maintenance Director will be responsible for the continued compliance of 2600.100 B and ensure no snow or ice accumulates around emergency exits.

5. To ensure ongoing compliance the Administrator or Maintenance Director will complete weekly audits of all emergency exits to ensure no snow or ice is blocking compliance. Audit results will be reviewed during monthly Quality Assurance meetings for compliance monitoring and corrective action if needed. This audit is included

Licensee's Proposed Overall Completion Date: *03/13/2026*

Implemented [redacted] 03/23/2026)

224a - Preadmission Screen Form

2. Requirements

2600.

224a Preadmission Screen Form *(continued)*

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 [redacted] was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]; however, the resident's preadmission screening form did not have the date the screening was completed.

Repeat Violation: [redacted]

Plan of Correction ***Accept [redacted] - 03/23/2026)***

1. On 2/11/26 the facility completed a full audit of the preadmission screening forms for Resident #2. Documentation was completed to clearly indicate on what date the form was completed. On 2/11/26 the Admissions Coordinator and Administrative staff responsible for completing preadmission screenings received re education on 55 Pa Code §2600.224(a) requirements, specifically: Completion of all required fields on the Department preadmission screening form. These updates and trainings are included.

2. A 100% audit of all resident's preadmission screenings was completed to ensure all fields are filled out completely. This audit is included.

Additionally, the facility implemented a Preadmission Screening Verification Process, requiring: Completion of all sections of the Department preadmission screening form prior to admission approval. This includes mandatory documentation of date of screening. This ensures a secondary administrative review prior to final admission approval.

Lastly The facility updated the Admission Checklist to include: Verification that preadmission screening form is fully completed, Verification that the date of assessment is completed. This updated admission checklist is included.

3. On 2/11/26 the Admissions Coordinator and Administrator received re education on 55 Pa Code §2600.224(a) requirements, specifically: Completion of all required fields on the Department pre admission screening form,

Additionally, on 2/11/26 The Admissions Coordinator and Administrator were trained on the newly implemented preadmission screening verification process. These trainings are included.

4. The Executive Director or designee Admissions Coordinator will be responsible for continued compliance of 224a pre admission screen form.

5. The Executive Director or designee Admissions Coordinator will complete weekly audit for 3 months of all residents to ensure all pre admission screening forms are 100% complete. These audits will be reviewed monthly by the quality assurance committee for compliance. This audit is included.

Licensee's Proposed Overall Completion Date: *03/13/2026*

Implemented [redacted] - 03/23/2026)

225a - Assessment 15 Days

3. Requirements

225a - Assessment 15 Days *(continued)*

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 [redacted] was admitted on [redacted]; however, the resident's assessment was not completed until [redacted]. Resident [redacted] assessment, has not been updated to include the resident's recent falls, loss of mobility, and increased care needs at the facility. Resident assessment has not been updated to reflect resident's significant health decline.

Repeat violation: [redacted]

Plan of Correction ***Accept [redacted] - 03/23/2026)***

1. On 2/11/26 the facility completed a comprehensive review and update of Resident #1's support plan to include: the residents recent falls, loss of mobility and increased care needs at the facility. The updated assessment was reviewed and signed by the Administrator/designee. Documentation was placed in the resident record.

On 2/11/26 the facility completed a 100% audit of all current residents to verify: Initial assessment completed within 15 days of admission, All required assessment elements are present and complete. This audit is included

2. On 2/11/26 The facility implemented an Initial Assessment Completion & Verification Process, requiring: Admission Tracking System which includes All new admissions are entered into an Admission Tracking Log. The log automatically identifies: Admission date initial Assessment due date (Day 15). This tracking system is included.

Additionally on 2/11/26, the facility implemented a standardized Assessment Completion Checklist. Required elements must be verified prior to finalizing assessment including: recent falls, loss of mobility and increased care needs at the facility, All required Department form sections completed. This checklist is included.
3. On 2/11/26 re-education was provided to: Wellness Director and executive director the Training included: §2600.225 assessment requirements, required assessment content elements and the 15-day completion timeframe expectations. Additional training was completed on how to use our newly implemented initial assessment completion and verification process, and assessment completion checklist.

4. The Executive director or designee Resident Care Coordinator will be responsible for complete compliance of 225a assessment 15 days.

5. The Executive Director or designee Resident Care Coordinator will complete weekly audit for 3 months of all residents to ensure all initial assessments are done within 15-day frame and that all required elements are completed in the assessment. These audits will be reviewed monthly by the quality assurance committee for compliance. This audit is included.

Licensee's Proposed Overall Completion Date: *03/13/2026*

Implemented ([redacted] 03/23/2026)

234d - Support Plan Revision

4. Requirements

234d - Support Plan Revision *(continued)*

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident [redacted] support plan dated [redacted] does not have the support plan sections completed for supervision needs, mobility needs, and medication needs completed.

Plan of Correction ***Accept [redacted] - 03/23/2026)***

1. Resident #3's Support Plan was immediately reviewed and revised on 2/11/26 by the Administrator. The sections related to supervision needs, mobility needs, and medication needs were completed to accurately reflect the resident's current care requirements. This documentation is included.

2. The home has implemented the following corrective measures: On 2/11/26 The Administrator conducted a 100% comprehensive review of all support plans to ensure required sections including supervision, mobility, medication needs, ADLs, and behavioral supports are fully completed. This audit is included.

Additionally, on 2/11/26 a Support Plan Completion Checklist has been implemented to ensure that all required sections are addressed before the plan is finalized. This checklist is included.

3. On 2/11/26 the Administrator and Resident Care Coordinator responsible for completing support plans have been retrained on 55 Pa. Code §2600.234 – Support Plans, including requirements for complete documentation of resident needs. This training is included.

4. The Executive Director or Resident Care Coordinator will be responsible for complete compliance of 234d support plan revision.

5. The Executive Director or Resident Care Coordinator will complete weekly audit for 3 months of all residents to ensure all resident support plans are being reviewed and that all sections of the support plan are thoroughly completed. These audits will be reviewed monthly by the quality assurance committee for compliance. This audit is included.

Licensee's Proposed Overall Completion Date: *03/13/2026*

Implemented [redacted] 03/23/2026)